MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05716

CERTIFICATE OF DEATH

05711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LEWIS	Clifford	RENSHAW	APRIL	3	1969	2:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	12-1-99	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	SUBURBAN	Retired Painter	***

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	BETHESDA	YES ☒ NO ☐	9946 MAYFIELD DR.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	W.	RENSHAW	MARY	K	MEYER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	***	214-14-4815	Miss Mamie Renshaw	Address as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several years

DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral, Chronic, pyelonephritis — several years

DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral ureteral obstruction by calculi several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 1950 to 4-3, 19 69 that (I) ~~(we)~~, last saw the deceased alive on 4-3 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George A. Gray, Jr. M.D.	M.D.	☒	☐	☐	4-3-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George A. GRAY, JR. M.D.	4714 Chevy Chase Drive Chevy Chase, Md. 20015

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-7-69	Rockville Cemetery	Rockville, Monty. Co. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, 7557 Wisconsin Ave. Bethesda, Maryland	APR 7 1969	Charles Judge

VR A15 (3) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05717

CERTIFICATE OF DEATH

05712
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6401 KENNEDY DRIVE

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 6401 KENNEDY DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORINE Middle J. Last REYNOLDS

4. DATE OF DEATH: Month April Day 3 Year 1969

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-27-1896

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MICHIGAN

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: J. TAYLOR JANNEY

14. MOTHER'S MAIDEN NAME: ANNA OSTRANDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 578-46-7433B

17. INFORMANT: MAJ. GEN. RUSSEL B. REYNOLDS, HUSBAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
4369
DUE TO
(b): GENL ARTERIOSCLEROSIS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CARCINOMA OF COLON- ANEMIN 2° CA-

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from NOV, 1967, to April 3, 1969, that I last saw the deceased alive on April 1, 1969, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L. Flynn M.D. M.D. — ADDRESS (Street, city or town, state): 916 19th St NW WASH DC — DATE SIGNED

PHYSICIAN'S NAME (Type): ROBERT L. FLYNN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-7-1969

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON MEM. CEM.

22d. LOCATION (City, town, or county) (State): ARLINGTON COUNTY, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: JOSEPH GAWLER'S SON, INC. 3380 WISC. AVE., N. W. WASH., D. C. 20016

24a. REC'D BY REGISTRAR DATE: APR 7 1969

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL ING PHYSICIAN: The law requires that the death certificate be executed within ? er death. Page 4
may be retai aspital or attending physician. s funeral director,
TO FUNERAL D. After this certificate has been signed by the attending physician and completely fil page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages hould be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

05718

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05713

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Katherine	Middle: P.	Last: Reynolds	
2a. DATE OF DEATH Month: April Day: 26 Year: 1969	2b. HOUR: 10 PM		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 01-22-1893	6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Potomac Valley Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auditor	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Wash., D.C.	13b. COUNTY: ~~Washington~~	13c. CITY OR TOWN: Wash., D.C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 4550 Conn. Ave. N.W.
14. FATHER'S NAME First: Oswald	Middle: B.	Last: Parsons	15. MOTHER'S MAIDEN NAME First: May	Middle: M.	Last: Grove[illegible]
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Mrs. Mae Harbold-117 Monticello Ave. Annapolis, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Myeloma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 months
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 203 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from Sept., 1967, to present, 19____, that (I) (~~we~~) last saw the deceased alive on April 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Arthur J. Anderson M.D. DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: April 26, 1969	
22d. PHYSICIAN'S NAME (Type): Arthur J. Anderson	22e. ADDRESS: 916 19th Street N.W. Wash D.C.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/29/69	23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery	23d. LOCATION (City or Town): Washington, D. C.	(County) (State)
24. FUNERAL DIRECTOR: The P.H. Hines Co	ADDRESS: 29[illegible] 14 St. N.W. Washington, D.C.	25a. ACCEPTED BY REGISTRAR DATE: APR 30 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05714

1. DECEASED-NAME (Type or Print): First William Middle F. Last Rhodes
2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☒: Month 4/16 Day Year 1969
2b. HOUR 10:05 M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 11/25/18
6. AGE (In years last birthday): 50 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
2c. DATE PRONOUNCED DEAD: Month 4/16 Day Year 1969
2d. HOUR 10:20 M
7a. BIRTHPLACE (State or foreign country): Dist of Co.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Plumber
12b. KIND OF BUSINESS OR INDUSTRY: Private
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Mont.
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 828-Baltic Rd.
14. FATHER'S NAME: First William Middle T. Last Rhodes
15. MOTHER'S MAIDEN NAME: First Louise Middle Last Powell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): Navy WWII
16b. SOCIAL SECURITY NO.: 579-01-3297
17. INFORMANT: Marjorie Rhodes ADDRESS: Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute.
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Arterio Sclerosis.
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4123
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden. Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED: April 17, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/19/69
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Memorial Park
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: APR 18 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05720 Elizabeth Marie

CERTIFICATE OF DEATH

05715

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Baby	Girl	Richardson	4 15 69	2 10 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
F	W	4-14-69	— YRS.	1	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.			Montgomery Co. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring, Md	Holy Cross Hosp		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Mont.	Rockville	YES ☒ NO ☐	14111 London Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	E	Richardson	Patricia	Christine	Dooley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Central Nervous System damage according to Coroner

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 4-14, 19 69, to 4-15, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 4-15 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Raymond J. Gibbons M.D.		☑	☐	☐	4-15-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Raymond J. Gibbons	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/16/69	Gate of Heaven	Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler 1331 Rock. Pike, Rockville, Md	APR 18 1969	Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5, 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05721

05716

1 DECEASED NAME (Type or Print)	First: Betty	Middle: Eilene	Last: Begby.	2a DATE KNOWN OF DEATH ESTIMATED ☐	Month: April	Day: 8	Year: 1969	2b HOUR: M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: June. 21 1918	6 AGE (in years last birthday): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month: April	Day: 8	Year: 1969	2d HOUR: 8 03 A M
7a BIRTHPLACE (State or foreign country): Ohio	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Montgomery Md						
10 CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10300 West Lake Dr.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Navy Nurse	12b KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Mont	13c CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 10300 W Lake Dr.					
14. FATHER'S NAME First: Thomas	Middle:	Last: Begby	15. MOTHER'S MAIDEN NAME First: Emma	Middle:	Last: Burley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): U.S. Navy	16b. SOCIAL SECURITY NO	17. INFORMANT: Kenneth Begby	ADDRESS: 7280 Pascoe Rd. Pennington						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fatty Meta. Morhosis of Liver. Acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Chronic. Alcoholism. — Years.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Bethesda, Md
22b. DATE SIGNED: April 8, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 4-11-69	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State): Suitland Pr. Geo Md	
24. FUNERAL DIRECTOR: Robert A Pumphrey	ADDRESS: 7557 Wisconsin Ave Bethesda, Md	25a RECD BY REGISTRAR DATE: APR 15 1969	25b. REGISTRAR SIGNATURE: [signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05722

CERTIFICATE OF DEATH

0571

1 DECEASED-NAME (Type or print): First BERTHA Middle Last ROBERTS

2a. DATE OF DEATH: Month 4 Day 10 Year 69

2b HOUR: 1am

3 SEX: F

4. RACE: White

5. DATE OF BIRTH: 1-22-1882

6 AGE (In years last birthday): 87 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN

7a. BIRTHPLACE (State or foreign country): NEW York

7b CITIZEN OF WHAT COUNTRY? U.S.A

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery — Kensington — M.D. Md

10. CITY OR TOWN OF DEATH: Kensington - MD

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kensington Garden Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife

12b KIND OF BUSINESS OR INDUSTRY: At Home

13a. USUAL RESIDENCE (Where deceased lived at time of admission) STATE: Kensington MD

13b COUNTY: Montgomery

13c CITY OR TOWN: Kensington

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET AND NUMBER: 3534 Raymoor RD

14. FATHER'S NAME: First Henry Middle Last Towers

15. MOTHER'S MAIDEN NAME: First A. Middle Last Edward

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16b SOCIAL SECURITY NO. UNKNOWN.

17 INFORMANT: Nursing Home. Records — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) SEPTICEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) DECUBITUS ULCERS — 3 MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c) FRACTURED HIP — July 1968

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION: June 19 1968

19b CONDITION FOR WHICH OPERATION WAS PERFORMED: FRACTURED HIP

20a AUTOPSY? YES ☐ NO ☑

20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month 6 Day 18 Year 68

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) SLIPPED & FELL AT HOME

21d. INJURY OCCURRED While at work ☐ Not while at work ☑

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) RESIDENCE

21f. LOCATION Street or R.F.D. No. 3534 RAYMOOR RD. City or Town Kensington County Montgomery State Md

22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to April, 1969, that (I) (we) last saw the deceased alive on APRIL 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22c DATE SIGNED: 4/10/69

22d PHYSICIAN'S NAME (Type) DR LEO I DONOVAN

22e ADDRESS 5217 WISCONSIN AVE Bethesda MD

23a BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b DATE: 4-12-69

23c NAME OF CEMETERY OR CREMATORY: Waterville Crematory

23d LOCATION (City or Town) Waterville (County) New York (State)

24 FUNERAL DIRECTOR: Robert A Pumphrey — Address: 7557 Wisconsin Ave Bethesda, Md

25a RECD BY REGISTRAR (DATE): APR 15 1969

25b REGISTRAR (SIGNATURE): [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05723 05718

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JAMES	NMN	ROBINSON	4	9	69	2:30PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
MALE	COLORED	7- -1902	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
	USA		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
OLNEY	MONTGOMERY GENERAL	UNKNOWN	UNKNOWN

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	BROOKEVILLE	YES ☐ NO ☒	19927 ZION ROAD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
UNKNOWN			UNKNOWN		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
UNKNOWN		MEDICAL RECORD DEPT.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Septic Cranial Hemorrhage — Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Hemiplegia

DUE TO, OR AS A CONSEQUENCE OF (c) Cardio-Arterio sclerosis ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 3-22-69 to 4-9-69, that (I) (~~we~~) last saw the deceased alive on 4-9-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Jack Schumacher					4-9-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JACK SCHUMACHER, M. D.	RUSSELL AVE., GAITHERSBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-12-69	Mt Zion Cem.	MT ZION, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
R. F. Snouffer	Rockville	APR 17 1969	Marion Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05724 05719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First / Middle / Last	Elsie Irene Rogers	2a. DATE OF DEATH Month / Day / Year	4 15 69
2b. HOUR	12 M		
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH	4-19-25	6. AGE (In years last birthday)	43 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Montgomery Md.
10. CITY OR TOWN OF DEATH	Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Washington San & Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	-
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE	Maryland	13b. COUNTY	Prince Geroges
13c. CITY OR TOWN	Lanham	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET AND NUMBER	7203 Kempton Rd.		
14. FATHER'S NAME First / Middle / Last	William McNamara	15. MOTHER'S MAIDEN NAME First / Middle / Last	Neta Thomas
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)	-
16b. SOCIAL SECURITY NO.		17. INFORMANT Address	Joseph H. Rogers - above address (Husband)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Hepatic Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis from Ca Breast — 5 mos

DUE TO, OR AS A CONSEQUENCE OF (c) Ca Breast — 14 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 174X

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	2/2/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	Ca Breast
20a. AUTOPSY? YES [ ] NO [X]		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	
21f. LOCATION Street or R.F.D. No. / City or Town / County / State			

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan, 19 68, to April 15, 1969, that (I) (~~we~~) last saw the deceased alive on April 15 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	R.N. Sandstrom MD	DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)	R. N. Sandstrom MD	22e. ADDRESS	7701 Carroll Ave Takoma, Md

23a. BURIAL, CREMATION, REMOVAL	Burial	23b. DATE	4/18/69	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
23d. LOCATION (City or Town) (County) (State)	Colmar Manor, Md.			
24. FUNERAL DIRECTOR	Nalley's Funeral Home Inc.	ADDRESS	Mt. Rainier, Maryland	
25a. REC'D BY REGISTRAR DATE	APR 21 1969	25b. REGISTRAR'S SIGNATURE	[illegible] Judge	

VR A15 (8) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05725

0572(1)

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Peter	Joseph	Romola	April 17, 1969	1:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	29 July 1914	54 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Washington, D.C.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Electrician	U.S. Govt.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Virginia	Loudoun	Sterling	YES [X] NO [ ]	804 West Poplar Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Romola	Talina		(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	1941-46	578-09-4721	The Medical Record	The Clinical Center, NIH, Bethesda Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	36 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic heart disease	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

4104

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 15 April, 19 69, to 17 April, 19 69, that (I) (we) last saw the deceased alive on 17 April 19 69, and that (to my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Amiel Segal		[ ]	[ ]	[X]	17 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Amiel Segal, M.D.	The Clinical Center, National Institutes of Health, Bethesda Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	21 Apr 69	National Memorial Park	Falls Church, Fairfax, Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Money & King Funl. Home, Vienna, Va.	APR 22 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05726 — 05721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: SEMA	Middle:	Last: ROSIN	2a. DATE OF DEATH Month: 4 Day: 27 Year: 69	2b. HOUR: 11 01 M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 4/5/10	6. AGE (In years last birthday): 59 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): RUSSIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery		Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: Chevy Chase	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: 2308 Washington Ave		
14. FATHER'S NAME First: HERMAN	Middle: EUGENE	Last: SHIPORNIKIN	15. MOTHER'S MAIDEN NAME First: TOBEY	Middle: —	Last: (UNK.)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 578-62-4487	17. INFORMANT: MRS ELI ROSEN	Address: (Same as 13 above)		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 60 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral vascular disease - hypertension — 1 yr
DUE TO, OR AS A CONSEQUENCE OF (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4310

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from June, 1964, to April 27, 1969, that (I) (~~we~~) last saw the deceased alive on April 27, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Simon C. Weiner MD — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: April 28, 1969

22d. PHYSICIAN'S NAME (Type): SIMON C. WEINER, MD — 22e. ADDRESS: 8201-16th St. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 4-29-69	23c. NAME OF CEMETERY OR CREMATORY: NAT'L CAP. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): WASH. D.C.	
24. FUNERAL DIRECTOR: Goldberg Funeral Home	ADDRESS: 2179 21st St. SE	25a. RECD BY REGISTRAR DATE: APR 30 1969	25b. REGISTRAR'S SIGNATURE: [illegible]	

VR A 5 (a)
30M REV. 7/68

1

05727

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05722

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Robert	Henry	ROY	April	17	1969	940A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M.N.
Male	Caucasian	June 19, 1937	31 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Massachusetts	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Naval Hospital	U. S. Navy	N/A

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	St.Mary's	Park Lexington	YES ☐ NO ☒	Route 2, Box 107-116

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry Vincent		Roy	Mary Louise		Francoeur

16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
yes 1954-1968	023-28-3244	Navy Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Necrotizing arteritis; confluent bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that ☒ (I) (this hospital) attended the deceased from March 16, 1969, to April 17, 1969, that ☒ (I) (we) last saw the deceased alive on April 17 1969, and that in ☒ (my) (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
John A. Routenberg					April 18, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A. Routenberg, M. D.	Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	4-21-69	Notre Dame Cemetery	Fall River,		Mass.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. W. Chambers Co.	1400 Chapin Street, N.W., Washington, D.C.	APR 22 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05728 05720

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 DECEASED NAME (Type or print)	First Lydia	Middle E.	Last Ruedi	2a. DATE OF DEATH Month April Day 30 Year 1969	2b HOUR 2:15 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH 8/20/15	6 AGE (In years last birthday) 53 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH Montgomery		Md.
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dietary - Cook	12b KIND OF BUSINESS OR INDUSTRY N.I.H		
13a. USUAL RESIDENCE (Where deceased lived, if not in institution. Residence before admission) Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Glen Mar Park	13e. INSIDE CITY LIMITS? YES ☐ NO ☐	13d. STREET AND NUMBER 5304 Augusta Street	
14 FATHER'S NAME First FENNER	Middle	Last ELLIOTT	15. MOTHER'S MAIDEN NAME First MARY	Middle M.	Last WOOLLARD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Joseph Ruedi - Husband - Address			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aneurysm, ruptured, circle of Willis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4009

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from JUNE, 1965, to APRIL, 1969, that (I) ~~(we)~~ last saw the deceased alive on 4/29 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE [signature] MD DEGREE — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 4/30/69

22d. PHYSICIAN'S NAME (Type) DR LEO DONOVAN — 22e. ADDRESS 6212 WISCONSIN AVE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-3-1969	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) Rockville	(County) Montgomery Co.,	(State) Md.
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.	ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20015	25a. REC'D BY REGISTRAR DATE MAY 8 1969	25b. REGISTRAR'S SIGNATURE [signature]		

VR A15 Y4
45M 1/69

FOR STATE HEALTH DEPT.

05729

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05721

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First Ida	Middle Flora	Last Rush	2a DATE KNOWN OF DEATH ESTIMATED ☒	Month 4	Day 30	Year 1969	2b HOUR 3:45 A.M.			
3 SEX F	4 RACE W	5 DATE OF BIRTH 7/11/1875	6 AGE (In years last birthday) 93 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	2c DATE PRONOUNCED DEAD Month April	Day 30	Year 1969	2d HOUR 5:15 A.M.		
7a. BIRTHPLACE (State or foreign country) Mississippi	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH Montgomery Md								
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) At Home	12b KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). STATE Mississippi	13b COUNTY Lauderdale	13c CITY OR TOWN Meridian	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER 2501 Poplar Springs Drive							
14. FATHER'S NAME First –	Middle	Last Smith	15. MOTHER'S MAIDEN NAME First	Middle UNK.	Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	(If yes give war or dates of service)	16b SOCIAL SECURITY NO 425-94-9311	17 INFORMANT 6014 Conway Rd. ADDRESS Bethesda Md. Evelyn E Mattox - daughter								

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebral Insufficiency Acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Yrs.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebral Vascular Disease — 4 Yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Catherine Bell M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b DATE SIGNED April 30, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Removal-Burial	5-1-1969	Magnolia Cemetery	Meridan, Lauderdale Co., Miss.

24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016

25a RECD BY REGISTRAR DATE MAY 6 1969

25b REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15, 10M REV. 1/68

Item17 FilmG411
4/15/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05725

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)	First: Vincent	Middle: John	Last: Russo	2a DATE KNOWN OF DEATH ☒ ESTIMATED ☐	Month: 4-	Day: 5	Year: 69	2b HOUR: 3:00 M
3 SEX: M	4 RACE: W	5 DATE OF BIRTH: 4-18-14	6 AGE (In years last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 4-	Day 5	Year 969	2d HOUR: 3:00 P M
7a BIRTHPLACE (State or foreign country): Balto., Md.	7b CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Montgomery						Md
10. CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San. & Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Book Binder-Forman	12b KIND OF BUSINESS OR INDUSTRY: Bureau of Engraving U.S. Gov't						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Montgomery	13c CITY OR TOWN: Hyattsville	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 6804 Knollbrook Dr. W. Hyattsville					
14. FATHER'S NAME First / Middle / Last: Anthony Russo		15 MOTHER'S MAIDEN NAME First / Middle / Last: Sadie Demma							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 216-07-4962	17 INFORMANT: Lillian Russo (Nee Plumhoff) above, wife	ADDRESS: Plumhoff						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4:23
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, City or Town, and County): Hyattsville
22b. DATE SIGNED: April 5, 1969

23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/9/69	Oak Lawn Cemetery	Balto., Md.

24 FUNERAL DIRECTOR: Schimunek Funeral Home ADDRESS: 3331 Brehms Lane 31313

25a REC'D BY REGISTRAR DATE: APR 11 1969

25b REGISTRAR'S SIGNATURE

VR A15ME (5)
10M REV. 1/68

2 16

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05731

05726

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
BETTY	Z.	SAGER	4 -20- 69	12:24 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	3-15-1900	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
POLAND	U.S.A	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	MONTGOMERY COUNTY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS HOSP	HOUSEWIFE	H.W.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
M.D	PRINCE GEORGES	BELTSVILLE	YES ☒ NO ☐	11322 CHERRY HILL RD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JACOB JOSEPH		CLARFIELD	MINNIE		FINKELSTEIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		101-14-7298	SAGER, HAROLD W.	11346 CHERRY HILL RD BELTSVILLE, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio - Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Carcinoma -- Primary Unknown.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from April 11, 1969, to April 20, 1969, that (I) (~~we~~) last saw the deceased alive on April 20 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Bernard A. Heckman, M.D.		☑	☐	☐	April 20, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
BERNARD A. HECKMAN, MD	8107 EASTERN AVE, SIL. SP. MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-21-69	BETH DAVID CEM.	ELMONT, L.I., N.Y.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GOODRICH FUNERAL HOME 421 79TH ST BKLYN	APR 23 1969	

VR A15 (4)
30M REV. 1/68

Item23 FilmG112
4/30/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05727

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)	First: Peter	Middle: P	Last: Santianni	2a DATE KNOWN OF DEATH ESTIMATED ☒	Month: April	Day: 21	Year: 1969
2b HOUR	12:15 P M						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c DATE PRONOUNCED DEAD	Month: April Day: 21 Year: 1969
2d HOUR	1:30 P M						
Male	White	Sept. 6, 1926	42 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH				
Pennsylvania	U.S.A.		Montgomery Md				
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban Hosp	ARCHITECT					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
Md	Mont	Rockville	YES ☐ NO ☐	10500 Rockville Pike			
14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last		
Michael		Santianni	Adeline		Fumagnoli		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes give war or dates of service	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS			
yes	World War II		Louise Santianni				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M.D

EXAMINER'S NAME (Type) JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Bethesda, Md.

22b DATE SIGNED April 22, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4-25-69	Oakland Cemetery / Holy Cross Cemetery	Philadelphia Yeadon, Penna.

24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland — ADDRESS

25a RECEIVED BY REGISTRAR DATE APR 23 1969

25b REGISTRAR'S SIGNATURE Florence Judge

VR A15ME (5)
10M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-A
45M 3-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05739 — 05728

1 DECEASED NAME (Type or print) First: MARY	Middle: NMN	Last: SARGENT	2a DATE OF DEATH Month Day Year: 16 APRIL 1969
2b HOUR: 0420A M			
3 SEX: FEMALE	4 RACE: CAUC	5 DATE OF BIRTH: 15 MARCH 1903	6 AGE (In years last birthday): 66 YRS.
IF UNDER 1 YEAR: MONTHS 1 DAYS 4	IF UNDER 24 HRS: HOURS MIN.		
7a BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: MONTGOMERY Md
10 CITY OR TOWN OF DEATH: BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): NAVAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: VIRGINIA	13b COUNTY: V	13c CITY OR TOWN: ARLINGTON	13d INSIDE CITY LIMITS? YES ☐ NO ☐
13e STREET AND NUMBER: 4990 COLUMBIA PIKE, APT 409			
14. FATHER'S NAME First: UNKNOWN	Middle	Last	15. MOTHER'S MAIDEN NAME First: UNKNOWN Middle Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT: Hospital records Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROX MATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Metastatic Carcinoma of the Kidney

DUE TO, OR AS A CONSEQUENCE OF
(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☒ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that ☒ (this hospital) attended the deceased from 2 FEBRUARY 19 69, to 16 APRIL, 19 69, that ☒ (we) last saw the deceased alive on 16 APRIL 1969, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert E. Chambers, MD	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED: 17 Apr 1969
22d. PHYSICIAN'S NAME (Type): ROBERT E. CHAMBERS LT MC USN		22e ADDRESS: Naval Hospital, Bethesda, Md.			

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-19-69	23c NAME OF CEMETERY OR CREMATORY: Mt. Wolloston Cemetery	23d LOCATION (City or Town) (County) (State): Quincey, Mass	
24 FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home	ADDRESS: 7757 Wisconsin Ave. Bethesda M.	25a DATE REC'D BY REGISTRAR: APR 21 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

Item 1: Film 411 4-24-69a

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05734 05729

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	PHILHOWER	SCHIEFER	4 - 8 - 69	8:52 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
F	W	1-13-74	95 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
PENNA.	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASH. SAN. & HOSP.	NONE	—

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	P.G. COUNTY	BETHESDA/HYATTSVILLE	YES ☒ NO ☐	7809 Chelton Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	W	SNYDER	ELIZABETH		TYGER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—		DAUGHTER	7809 CHELTON RD. BETHESDA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral Vascular Accident	Days
DUE TO, OR AS A CONSEQUENCE OF (c)	Cerebral Vascular Insufficiency	yrs.

4377
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Severe decubitus & confusion

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this ~~hospital~~) attended the deceased from Dec 1968, 19 66, to April 8, 19 69, that (I) (we) last saw the deceased alive on April 7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
Harold W. Draper M.D.					4/8/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	
HAROLD W. DRAPER M.D.	9501 GEORGIA AVE.	SILVER SPRING, Md. 20910

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-10-69	Union Cemetery	Rossiter, Penna.

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A. Humphrey	7557 Wis	APR 15 1969	Wanda Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4) 45M 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-2
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05735 05730

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
James	Taylor	Schmick	4 18 69	2:10 AM

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	6-30-1900	68 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Sunbury, Penna	USA		Montgomery Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Takoma Pk	Washington San & Hospital	Retired Engineer	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER
Maryland	Montgomery	Silver Spring		1101 Dale Dr

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George		Schmick	Anna		Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
yes 6/30/18-1919	089-07-6683	Mildred Schmick (wife)	Silver Spring, Md. 1101 Dale Drive

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	Few minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart failure & Pulm Edema	2 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Cardiovasc. Dis. C.H.F.	3 mo

Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from July, 1968 to April 18, 1969, that (I) (we) last saw the deceased alive on April 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
James A. Whitlock	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	4-18-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
James Whitlock	7717 Carroll Ave. Takoma Park, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Apr. 22, 1969	Parklawn Cemetery	Rockville, Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Carter & Pumphrey, Warner E. Pumphrey, Inc.	Maryland 8434 Ga. Ave. Sil. Spg.	APR 22 1969	Charles Judge

Altered to Mod. Examiner (Cl)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05736

CERTIFICATE OF DEATH

05731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Harry	Middle: William	Last: Schoening	2a. DATE OF DEATH Month: April Day: 12 Year: 1969	2b. HOUR: 9:13 M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 10/8/1886	6. AGE (in years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARR ED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md	
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Univ. Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired): Veterinarian	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN: Washington D. C.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 5504 Nebraska Ave. N.W.
14. FATHER'S NAME First Middle Last: Harry Schoening		15. MOTHER'S MAIDEN NAME First Middle Last: Sarah Frank		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WWI	16b. SOCIAL SECURITY NO.: 579-60-3346	17. INFORMANT Address: William Rech-700 Welsh Rd. Apt. B-16 Huntingdon Valley, Pa.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular Accident — Approx. Interval Between Onset and Death: 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis — Approx. Interval Between Onset and Death: several yrs
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prostatectomy

19a. DATE OF OPERATION: 1964	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from [illegible], 19[illegible], to 4/12/69, 19[illegible], that (I) (we) last saw the deceased alive on 4/12/69 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 4/12/69

22d. PHYSICIAN'S NAME (Type): LYNWOOD HEIGES, M.D., F.A.C.A. — 22e. ADDRESS: 15015 Flower Valley Court, Rockville, Maryland 20853

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 4/16/69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION (City or Town) (County) (State): Arlington, Virginia	
24. FUNERAL DIRECTOR: The S.H. Hines Co.	ADDRESS: Washington, D.C.	25a. REC'D BY REGISTRAR DATE: APR 16 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15 (4) 45M /69

1

05737

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05732

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
Baby	Boy	Seal	4	01	1969	6.20 PM

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Male	White	3.30.69	YRS	2 DAYS	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	United States	NEVER MARRIED [X]	Montgomery Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Olney	Montgomery General		

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md	Montgomery	Derwood	YES [ ] NO [#]	5904 Muncaster Mill Rd

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Milford		Seal	Ruthie	Estelle	Parks

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT Address
no	None	Hospital Records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary atelectasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2d.

DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity (4th) — 2d.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 3/30, 19 69, to 4/1, 19 69, that (I) (we) last saw the deceased alive on 4/1, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c DATE SIGNED
[signature]	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	4/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Charles H. Ligon M.D.	Sandy Spring, Md.

23a BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 3 1969	Seal Farm	Etchison Mont. Md.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Francis H. Barber	Laytonsville Md.	APR 7 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
30M REV 68

1 1

05733

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05733

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A 45M 1-69

1 DECEASED NAME (Type or print): First RICHARD Middle A. Last SEBASTIAN SR

2a. DATE OF DEATH: Month 4 Day 28 Year 69

2b. HOUR 5 45 PM

3 SEX: Male

4. RACE: WHITE

5 DATE OF BIRTH: 3-4-1897

6. AGE (In years last birthday) 72 YRS — IF UNDER 1 YEAR: MONTHS 1 DAYS 25 — IF UNDER 24 HRS: HOURS MIN

7a BIRTHPLACE (State or foreign country): Ill.

7b CITIZEN OF WHAT COUNTRY? U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. COUNTY OF DEATH: MONTGOMERY Md.

10. CITY OR TOWN OF DEATH: Silver Spring

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 2015 E.W. Highway

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)

12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.

13b COUNTY Montgomery

13c CITY OR TOWN Bethesda

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 5912 Wilmett Road

14 FATHER'S NAME First Erich Middle Last Scherubh

15 MOTHER'S MAIDEN NAME First Normal Middle Last CHANDLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)

16b SOCIAL SECURITY NO 443-14-3804

17 INFORMANT Address Silver Spring

A Chevy Chase Nsg. & Conv Center

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis & Cerebral Thrombosis

DUE TO, OR AS A CONSEQUENCE OF (c) Senility

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hrs / Indef. / Year

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

19a DATE OF OPERATION: none

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☐

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)

21f LOCATION Street or R.F.D. No City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1964, 19___ to 4/28/69 19___, that (I) (we) last saw the deceased alive on 4/28/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature] DEGREE ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED 4/28/69

22d. PHYSICIAN'S NAME (Type) William P. Argy M.D.

22e. ADDRESS 5201 Conn Ave Washington D.C.

23a BURIAL, CREMATION, REMOVAL (Specify) Cremation

23b. DATE 5-1-69

23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory

23d. LOCATION (City or Town) (County) (State) Suitland, Pr. Geo. Md.

24 FUNERAL DIRECTOR ADDRESS 7557 Wisconsin Ave Bethesda, Maryland

ROBERT A. PUMPHREY

25a RECD BY REGISTRAR DATE MAY 5 1969

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05739

CERTIFICATE OF DEATH

05734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Georges	Jack	Serabian	April 3 1969	4:25 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	12 March 1921	48 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
New York	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center	Attorney	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Chevy Chase	YES ☒ NO ☐	9216 Jones Mill Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Serabian	Elise		Boyajian

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW II	128-01-8627	The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lymphosarcoma

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2001

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 17 March, 1969, to 3 April, 19 69, that (I) (we) last saw the deceased alive on 3 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Sherrard Hayes MD					3 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sherrard L. Hayes, M. D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/7/69	Gate of Heaven Cemetery	Silver Spring, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, 5130 Wisconsin Ave., N.W. Washington, D.C.	APR 7 1969	Elizabeth Judge

VR A15 4C
30M REV 7/68

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05740

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-69

1 DECEASED NAME (Type or print) First: Odyce	Middle:	Last: Shaw.	2a. DATE OF DEATH Month: 4 Day: 17 Year: 69		2b. HOUR 2330
3 SEX: FEMALE	4. RACE: CAUC.	5. DATE OF BIRTH: 7-18-84	6. AGE (In years last birthday): 84 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MISSOURI	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY		Md
10. CITY OR TOWN OF DEATH: SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CARRIAGE HILL E.C.F.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: N.A.		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: D.C.	13b. COUNTY: D.C.	13c. CITY OR TOWN: WASHINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 4550 BRANDYWINE ST.	
14. FATHER'S NAME First: HENRY	Middle:	Last: KAUFMAN	15. MOTHER'S MAIDEN NAME First: ANN	Middle:	Last: (UNKNOWN)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 579-60-7794	17. INFORMANT: ARNOLD SHAW, SON,	Address: 4550 BRANDYWINE ST. NW WASH, D.C.		

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): MYOCARDIAL INFARCT, ACUTE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY ARTERY THROMBOSIS

DUE TO, OR AS A CONSEQUENCE OF (c): CORONARY ARTERY ATHEROSCLEROSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 WEEKS.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS, CONGESTIVE HEART FAILURE

MEDICAL CERTIFICATION

19a. DATE OF OPERATION: N.A.	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N.A.	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: N.A.
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner): N.A.	21b. TIME OF INJURY HOUR A.M. P.M Month: N.A. Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): N.A.	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.): N.A.	21f. LOCATION Street or R.F.D. No. City or Town County State: N.A.	

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from JANUARY, 19 69, to 17 APR, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 17 APRIL 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death

22b. SIGNATURE: Arnold B. Doty M.D. DEGREE	ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐	22c. DATE SIGNED: 17 APRIL 69	
22d. PHYSICIAN'S NAME (Type): DONALD B. DOTY	22e. ADDRESS: 1909 HANOVER ST., SILVER SPRING		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 4-21-1969	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Prince Georges Co. Md
24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SON, INC.	ADDRESS: 5130 WISC. AVE., N. W. WASH., D. C. 20016	25a. REC'D BY REGISTRAR DATE: APR 23 1969	25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05741

CERTIFICATE OF DEATH

05736

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. DECEASED NAME (Type or print) First: PEARL	Middle:	Last: SHRADER	2a. DATE OF DEATH Month: 4 Day: 15 Year: 1969 — 2b. HOUR: 10:30 AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: 4-10-1882	6. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Illinois	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Randolph Hills Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Stenographer	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D. C.	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET AND NUMBER: 653 East Capitol St. S.E.
14. FATHER'S NAME First: Peter	Middle:	Last: Shrader	15. MOTHER'S MAIDEN NAME First: Susan	Middle:	Last: Hartman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 579-60-4683	17. INFORMANT: Mrs. Jessie E. Smith	Address: Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hr.

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Coronary Artery Disease — over 5 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Vascular Thrombosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. — City or Town — County — State	

22a. I **certify** that (I) (this hospital) attended the deceased from Oct, 1962, to April 15, 1969, that (I) (~~we~~) last saw the deceased alive on April 15 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Louis H. Shuman, M.D. — DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 4-15-69	
22d. PHYSICIAN'S NAME (Type): Louis H. Shuman, M.D.	22e. ADDRESS: 1635 Mass. Ave. N.W., Wash., D.C.,		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-18-1969	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Suitland, Prince Georges Co.Md.	
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.	ADDRESS: 5130 Wisc. Ave. N.W., Wash., D.C., 20016	25a. REC'D BY REGISTRAR DATE: APR 18 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A 5 45M 1/69

FOR STATE HEALTH DEPT.

05742

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05737

- 1. DECEASED-NAME (Type or Print): First HARRY; Middle H; Last SILVERMAN
- 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] — Month 4, Day 24, Year 19 69
- 2b. HOUR: 6:10 M
- 3. SEX: M
- 4. RACE: WH
- 5. DATE OF BIRTH: 12/13/92
- 6. AGE (In years last birthday): 76 YRS
- 2c. DATE PRONOUNCED DEAD: Month 4, Day 24, Year 19 69
- 2d. HOUR: 6:10 AM
- 7a. BIRTHPLACE (State or foreign country): ROUMANIA
- 7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
- 9. COUNTY OF DEATH: MONTGOMERY, Md
- 10. CITY OR TOWN OF DEATH: SILVER SPRING Md.
- 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOLY CROSS
- 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): MERCHANT (RET.)
- 12b. KIND OF BUSINESS OR INDUSTRY: GROCERY
- 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
- 13b. COUNTY: Montgom
- 13c. CITY OR TOWN: ROCKVILLE
- 13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
- 13e. STREET AND NUMBER: 14119 Chesterfield Rd.
- 14. FATHER'S NAME: First SOLOMON; Last SILVERMAN
- 15. MOTHER'S MAIDEN NAME: First BERTHA; Last BRAUNSTEIN
- 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
- 16b. SOCIAL SECURITY NO.: 578-36-7125
- 17. INFORMANT: SYLVIA SILVERMAN — ADDRESS: 14119 CHESTERFIELD RD. ROCKVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

- 19a. DATE OF OPERATION:
- 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:
- 20. AUTOPSY? YES [ ] NO [X]
- 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH
- 21b. TIME OF INJURY Month, Day, Year: HOUR 12 PM, 4-6 1969
- 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18): Deceased scalded self in hot bath water
- 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
- 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home
- 21f. LOCATION Street or R.F.D. No.: (Above); City or Town: Rockville; County: Montgom.; State: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: 4/24/1969

EXAMINER'S NAME (Type): BELDEN REAP, MD.

ADDRESS (Street, city, town or county): Wheaton

- 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
- 23b. DATE: 4/27/69
- 23c. NAME OF CEMETERY OR CREMATORY: NATL. MEM. PARK
- 23d. LOCATION (City or Town) (County) (State): FALLS CHURCH, VA.
- 24. FUNERAL DIRECTOR: GOLDBERG FUNERAL HOME — ADDRESS: 4217 9th ST. N.W. D.C.
- 25a. REC'D BY REGISTRAR DATE: APR 28 1969
- 25b. REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5) 10M REV. 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in penal in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

05743 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

1 DECEASED-NAME (Type or Print) First: ROBERT HENRY SIMMONS	Middle	Last	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: April 25, 69	2b HOUR: 2:10 PM			
3 SEX: M	4. RACE: White	5 DATE OF BIRTH: March 10, 00	6. AGE (In years last birthday) YRS: 69	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month April Day 25 Year 1969	2d HOUR: 2:10 PM
7a BIRTHPLACE (State or foreign country): Mass.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Montgomery Md.				
10 CITY OR TOWN OF DEATH: Takoma Park,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Ret. Chemist - Gov't Printing Office	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c CITY OR TOWN: S.S.	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: 513 Margaret Drive			
14 FATHER'S NAME First: Charles Simmons	Middle	Last	15. MOTHER'S MAIDEN NAME First: Annie Perkins	Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): None (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Mary Simmons ----- Wife	ADDRESS				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic Heart Dis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Belden R. Reap, M.D.

ADDRESS (Street and No. or Town or County): Bladensburg

22b DATE SIGNED: April 25, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	April 29, 1969	Fort Lincoln Crematory	Bladensburg, Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.	APR 29 1969	Wanda Under

VR A15ME (5) 10M REV 1/68

2 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05744

CERTIFICATE OF DEATH

05739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Walter; Middle: Franklin; Last: Simms
2a. DATE OF DEATH: 4 Month 9 Day 69 Year
2b. HOUR: 12 45 A M
3. SEX: Male
4. RACE: Cau
5. DATE OF BIRTH: July 9?, 1883
6. AGE (In years last birthday): 85 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Grosvenor Lane Nsg. Home, 5721 Grosvenor Ln.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Farmer
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Glen Echo
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 20 Wellesley Circle
14. FATHER'S NAME First: Walter (error) Middle: Thomas Last: Garland Simms
15. MOTHER'S MAIDEN NAME First: Barbara Middle: Ann Last: Butler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown): No
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 228-44-6278-J
17. INFORMANT: Wilson Howard Simms (2.19 20770) Address: 9308 Edmondston Rd Greenbelt, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — APPROX. INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF (b): Broken heart failure and auricular fibrillation — 4 wks
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: None
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 4-8-1967, 19___, to 4-8-1969, that (I) (we) last saw the deceased alive on 4-8-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C P Ryland — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 4-9-69
22d. PHYSICIAN'S NAME (Type): C.P. RYLAND
22e. ADDRESS: 4400-49 St NW. Washington DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/9/69
23c. NAME OF CEMETERY OR CREMATORY: Good Hope Baptist Ch. Cem.
23d. LOCATION (City or Town) (County) (State): Spotsylvania, Co. Va.

24. FUNERAL DIRECTOR: S.H. Hines Co. Funeral Home — Tel. Co. 5-7023 — ADDRESS: Wash. DC 24 — 2901-14 St NW
25a. RECD BY REGISTRAR: APR 11 1969
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 141
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05745 05740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Federico	Paragas	SINLAO	April	17	1969	1135A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	Malaysian	18 August 1927	41 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Philippine Islands	Philippines		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Naval Hospital	Philippine Navy	N/A

13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
P. I.		Quezon City	YES ☐ NO ☐	191 Ermin Garcia, Cubao

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Donato		Sinlao	Paula		Paragas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or period of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	NONE	Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatoma with bile peritonitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Status postoperative laporotomy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from March 15, 1969, to April 17, 1969, that (I) (we) last saw the deceased alive on April 17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
D. L. Colgan M.D.				☒	April 17, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
D. L. Colgan, M. D.	Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-23-69	Layola Memorial Park	Manilla Philippine Island

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. Chambers Co. 1400 Chapin Street, N.W., Washington, D. C.	APR 23 1969	Charles Yeager

VR A15 (4)
30M REV 1/68

1

05746

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First: Gladys	Middle: —	Last: Slover	2a. DATE OF DEATH Month: April Day: 22 Year: 1969
2b. HOUR: 12 P M			
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: 9-1-03	6 AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Georgia	7b. CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington Sanitarium & Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C	13b. COUNTY	13c CITY OR TOWN: Washington DC	13d INSIDE CITY LIMITS? YES ☒ NO ☐
13e STREET AND NUMBER: 6806 Laurel Street			
14. FATHER'S NAME First: John	Middle:	Last: Slover	15 MOTHER'S MAIDEN NAME First: Hemmie	Middle:	Last: Little
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	If yes give war or dates of service:	16b. SOCIAL SECURITY NO: —	17. INFORMANT: Records - Washington Sanitarium & Hosp. Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO, OR AS A CONSEQUENCE OF

(b): Congestive Heart Failure — 1 month

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis — Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Osteoporosis - Severe kyphosis of spine

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County State

22a **I certify** that (I) (this hospital) attended the deceased from Apr. 24, 1968, to Apr. 22, 1969, that (I) (we) last saw the deceased alive on Apr. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Philip E. Jones M.D. DEGREE	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED: 4/22/69	
22d PHYSICIAN'S NAME (Type): Philip E. Jones M.D.	22e ADDRESS: 800 Pershing Drive Silver Spring Md. 20910		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: April 25, 1969	23c NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery	23d LOCATION (City or Town): Washington	(County)	(State) DC
24 FUNERAL DIRECTOR: Takoma Funeral Homes Inc.	ADDRESS: J.A. Walters, 254 Carroll St NW DC	25a REGISTRAR DATE: APR 24 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05747

CERTIFICATE OF DEATH

05742

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
Sherwood	F.	Smith	April	23	1969	11:45	PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	June 24, 1906	62 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U. S. A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg	4 N. Summit Drive	Owner	Farm machinery

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Gaithersburg	YES ☒ NO ☐	4 N. Summit Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Hench	Ezra Marcellus	Smith	Hester		Feaga

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No		214 09 2427	Mrs. Mildred Smith,	4 N. Summit Drive Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1958, 19___, to 4/23, 1969, that (I) (we) last saw the deceased alive on 4/17/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
L. I. Leal M.D.					April 24, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. I. Leal M.D.	Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	April 26, 1969	Frederick Memorial Park	Frederick	Frederick	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland	Frederick	APR 28 1969	J. Charles Jongs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (1) 30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05743 05743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 3 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Anne	Middle: Kane	Last: SNEERINGER	2a. DATE OF DEATH: April Month 29 Day 69 Year	2b HOUR: 1230PM
3 SEX: Female	4 RACE: Caucasian	5. DATE OF BIRTH: December 4, 1915	6. AGE (In years last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Montgomery Md.	
10. CITY OR TOWN OF DEATH: Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Virginia	13b COUNTY: Fairfax	13c. CITY OR TOWN: McLean	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 6635 Hazel Lane
14 FATHER'S NAME First: Matthew	Middle	Last: KANE	15. MOTHER'S MAIDEN NAME First: Marian	Middle	Last: HOFFA
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 172 01 0156	17 INFORMANT: Col. Earl A. Sneeringer	Address: McLean Virginia, 6635 Hazel Lane	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Carcinoma of the breast — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

174-X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a **I certify** that (X) (this hospital) attended the deceased from Mar. 3, 1969, to Apr. 29, 1969, that (X) (we) last saw the deceased alive on Apr. 29, 19 69, and that in (~~on~~) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: P. B. Blanchard	DEGREE: ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]	22c. DATE SIGNED: Apr. 30, 1969	
22d. PHYSICIAN'S NAME (Type): P. B. BLANCHARD, M. D.	22e. ADDRESS: Naval Hospital, Bethesda, Md.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/2/69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d LOCATION (City or Town) (County) (State): Arlington Arlington Va.	
24. FUNERAL DIRECTOR ADDRESS: Falls Church Funeral Home, 1102 West Broad St., Falls Church, Va.	25a REC'D BY REGISTRAR DATE: MAY 5 1969	25b. REGISTRAR'S SIGNATURE: Charles Yeager		

VR A-[illegible]
30M REV. [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05749

CERTIFICATE OF DEATH

05744

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Charles	McNeal	South	April 30 1969	4:50 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / M.N.
Male	White	20 November 1932	36 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Virginia	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center	T. V. Repairman	

13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER
Virginia	V	Roanoke		4948 Northlake Drive, N. W.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter	G.	South	Bess		Dunn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Not available	The Medical Records The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia with respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

2050

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute myelogenous leukemia — 6 months

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Recurrent pseudomonas septicemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 27 January, 1969, to 30 April, 1969, that (I) (we) last saw the deceased alive on 30 April 1969, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ira Goldstein	M.D.	[ ]	[ ]	[X]	30 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Ira M. Goldstein, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3-May 69	Bland Cemetery	Bland Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A Pumphrey	7557 Wisconsin Ave Bethesda, Md	MAY 5 1969	Charles Yeager

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1 68

MARYLAND STATE DEPARTMENT OF HEALTH

05750 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. DECEASED-NAME (Type or Print) First: HARRY	Middle: CHARLES	Last: SPARSHOTT	2a. DATE KNOWN OF / ESTIMATED DEATH: Month 4 Day 24 Year 1969	2b. HOUR 3:45 P.M.			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 4-4-01	6. AGE (In years last birthday): 68 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 4 Day 24 Year 1969	2d. HOUR 3:45 P.M.
7a. BIRTHPLACE (State or foreign country): Washington,	7b. CITIZEN OF WHAT COUNTRY?: D.C. U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery				Md.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Service Dept.	12b. KIND OF BUSINESS OR INDUSTRY: Wash. Gas Light				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: S.S.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 9316 Ocala St.			
14. FATHER'S NAME First: Charles	Middle: H.	Last: Sparshott	15. MOTHER'S MAIDEN NAME First: Cora	Middle: Mae	Last: Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: yes	17. INFORMANT: Linda Miller - [redacted]	ADDRESS: Newport News, 11510 Warwick Blvd., Va.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Cardiac Arrest secondary to — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

441.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Leaking Abdominal Aortic

DUE TO, OR AS A CONSEQUENCE OF (c): Aneurysm

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
4-24-1969	Leaking abdominal aortic aneurysm Cardiac arrest during surgery	YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
		Surgery

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): Belden R. Reap, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Give city, town or county): Silver Spring

22b. DATE SIGNED: April 24, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 28, 1969	George Washington Cemetery	Hyattsville, Maryland

24. FUNERAL DIRECTOR: Joseph Carter Evans (Acting) 8434 Georgia Avenue
Warner E. Pumphrey, Inc., Silver Spring, Maryland

25a. REC'D BY REG'STRAR DATE	25b. REGISTRAR'S SIGNATURE
APR 29 1969	Clarence Judge

1

05751

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05746

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: DANA; Middle: ASHTON; Last: SPRAGUE

2a. DATE OF DEATH: Month 4 Day 1 Year 69

2b. HOUR: 3 PM

3. SEX: MALE

4. RACE: White

5. DATE OF BIRTH: 6-24-03

6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): MASS.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md

10. CITY OR TOWN OF DEATH: SILVER SPRING

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wheaton Nursing Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): SALESMAN

12b. KIND OF BUSINESS OR INDUSTRY: SHOES

13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: ~~Wheaton~~ C.C.

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET AND NUMBER: 3702 Manor Rd

14. FATHER'S NAME: First HARRY; Middle RALPH; Last SPRAGUE

15. MOTHER'S MAIDEN NAME: First BESSIE; Middle —; Last RICH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —

16b. SOCIAL SECURITY NO.: 014-10-2200A

17. INFORMANT: V. FERN SPRAGUE - SAME AS #13 Address

MED CAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Uremia

DUE TO, OR AS A CONSEQUENCE OF (b): Kidney failure

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of prostate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

185 X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Arteriosclerosis

19a. DATE OF OPERATION: 2/17/69

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of prostate

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from Prior to, 19 65, to Death, that (I) (we) last saw the deceased alive on 3/26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: Chas B. Chanlan DEGREE: ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 4/1/69

22d. PHYSICIAN'S NAME (Type): JOHN B. UNHAU

22e. ADDRESS: 5805 Conn Ave. Chevy Chase, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 4/3/69

23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEM.

23d. LOCATION (City or Town) (County) (State): BLADENSBURG, MD.

24. FUNERAL DIRECTOR: JOS. GAWLER'S SONS ADDRESS: 5130 Wis. Ave. N.W. WASHINGTON, D.C.

25a. REC'D BY REGISTRAR DATE: APR 7 1969

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR AT5 (1)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05752 — 05741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Edith	Middle: B.	Last: Stevens	2a. DATE OF DEATH: Month April Day 5 Year 1969	2b. HOUR: 2:20 AM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: Dec. 14, 1903	6. AGE (In years last birthday): 65 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 209 Kimblewick Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own home			
13a. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 209 Kimblewick Drive		
14. FATHER'S NAME First: Clarence H.	Middle	Last: Miller	15. MOTHER'S MAIDEN NAME First: Mattie	Middle	Last: Strite	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 578-09-3601B	17. INFORMANT: Mitchell Stevens	Address: 209 Kimblewick Dr., S.S. Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Infarction — 6 years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.5

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 2/10/60, 19___, to 4/5/69 19___, that (I) (~~we~~) last saw the deceased alive on 4/5/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: John J. Curry M.D. — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: April 5, 1969

22d. PHYSICIAN'S NAME (Type): Dr. John J. Curry — 22e. ADDRESS: 9801 Georgia ave. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-8-69	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln cemetery	23d. LOCATION (City or Town) (County) (State): Washington, D.C.	
24. FUNERAL DIRECTOR: Paul F. Smith	ADDRESS: Warner E. Pumphrey 8434 Ga. ave. Sil. Spr. Md.	25a. REC'D BY REGISTRAR DATE: APR 11 1969	25b. REGISTRAR'S SIGNATURE: Clinton Judge	

VR A15 (4)
15M - 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05753

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05748

1 DECEASED NAME (Type or Print) First	Middle	Last
HARRY		STOLAR

2a DATE KNOWN OF DEATH ☒ EST. ☐ — Month 4 Day 2 Year 1969 — 2b HOUR 6:40 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Male	White	5/20/88	80 YRS.				

2c DATE PRONOUNCED DEAD Month 4 Day 2 Year 69 — 2d HOUR 6:40 A M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Lithuania	USA		Montgomery Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	merchant retired	Grocery

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Montgomery	Sil. Spg.	YES ☒ NO ☐	1220 E. W Hghwy SSMd.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
David		Stolar	Mildred	Ruth	Abrams

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
yes	WWII		wife Ida 1220 E.W Hghwy SSMd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Leap M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) BELDEN R. LEAP, M.D. ADDRESS (Street, City or Town, County) Wheaton

22b. DATE SIGNED APRIL 2, 1969

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4-4-69	B'nai Israel Cemetery	Oxon Hill, Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Funeral Corporation	3501 14th St NW	APR 7 1969	J. Charles Judge

VR A1SME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05754

CERTIFICATE OF DEATH

05749

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bethesda c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5503 Cromwell Drive	d. STREET ADDRESS: 5503 Cromwell Drive e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: EDWIN	Middle: WALTER	STROMWALL	4 DATE OF DEATH	Month: April	Day: 11,	Year: 1969	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIR: February 13, 1908	9. AGE (In years last birthday): 61 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service manager	10b KIND OF BUSINESS OR INDUSTRY: U. S. Steel	11 BIRTHPLACE (County & State or foreign country): Chicago, Illinois	12. CITIZEN OF WHAT COUNTRY?: U. S. A.					
13 FATHER'S NAME: Axel Stromwall	14. MOTHER'S MAIDEN NAME: Elfreda Larson							
15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO: 323-01-3994	17 INFORMANT: Dorothy L. Stromwall, Address 5503 Cromwell Dr. Bethesda, Maryland						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): DIFFUSED CARCINOMA WITH INTESTINAL BLEEDING — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): CARCINOMA, PRIMARY UNKNOWN — 9 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1966, 19__, to 4-11, 1969, that (I) (we) last saw the deceased alive on 4-10 1969, and that death occurred at 3:20 A M, from causes and on the date stated above.

22a SIGNATURE: Richard B. Perry M.D	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED: 4-11-69	
22c. PHYSICIAN'S NAME (Type): Richard B. Perry	22d ADDRESS: 2001 Eye St., N. W. Washington D. C.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b DATE THEREOF: April 11, 1969	23c NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d LOCATION (City or Town): Suitland, Maryland	(County) (State)
24 FUNERAL DIRECTOR: Joseph Gawler's Sons	ADDRESS: 5130 Wisconsin Avenue N. W. Washington D. C. 20016	25a REC'D BY REGISTRAR DATE: APR 15 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05755 — 05750

1 DECEASED NAME (Type or Print) First: Carl	Middle: H.	Last: Stutler	2a DATE KNOWN OF DEATH ESTIMATED ☐ Month: 4	Day: 29	Year: 69	2b HOUR: M
3 SEX: Male	4. RACE: Canc.	5 DATE OF BIRTH: May 1, 1899	6. AGE (In years last birthday): 69 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month: 4	Day: 29	Year: 1969	2d. HOUR: 9 A M

7a BIRTHPLACE (State or foreign country): W. Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md	
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10305 New Hamp. Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Carpenter Contractor	12b. KIND OF BUSINESS OR INDUSTRY: Building	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sil. Spr.	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 10305 New Hamp. Avenue

14 FATHER'S NAME First: Issac	Middle: W.	Last: Stutler	15. MOTHER'S MAIDEN NAME First: Minnie Middle: Radabaugh Last:
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: yes	17. INFORMANT: Grace O. Stutler	ADDRESS: Silver Spring Md. 10305 New Hampshire Ave.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Essential Hypertension — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

401 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): Belden R. Reap, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Hyattstown

22b DATE SIGNED: April 29, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 3, 1969	23c NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery	23d LOCATION (City or Town) (County) (State): West Milford West Virginia	
24 FUNERAL DIRECTOR: Carter Funeral Home, ADDRESS: Harber E. Purphrey, Inc. 8434 Ga. Ave. Sil. Spa. Md.	25a REC'D BY REG STRAR DATE: MAY 5 1969	25b. REGISTRAR'S SIGNATURE: Charles Yingling		

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05751

1 DECEASED-NAME (Type or Print) First: Donald	Middle: P.	Last: Stutler	2a DATE KNOWN OF DEATH ☒ / ESTIMATED ☐ Month: 4	Day: 24	Year: 1969	2b HOUR: 5:20 PM			
3 SEX: Male	4 RACE: Cauc.	5 DATE OF BIRTH: 11-17-1951	6 AGE (in years at last birthday): 17 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 4 / Day 24 / Year 1969	2d HOUR: 5:20 PM		
7a BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Montgomery Md.						
10. CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rear - Tak. Park Academy	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia	13b COUNTY: V	13c. CITY OR TOWN: Vienna	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 346 Court House Road					
14. FATHER'S NAME First: Donald	Middle: E.	Last	15. MOTHER'S MAIDEN NAME First: Ethel	Middle	Last: Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: Father	ADDRESS: Vienna, Virginia						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple Extreme Injuries including Fractured	
DUE TO, OR AS A CONSEQUENCE OF (b)	Skull with Exsanguination	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year: HOUR 3:15 PM 4-24- 69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Deceased, operating bulldozer, pinned under it when it overturned.
21d INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.): Field - Constr. Site	21f LOCATION Street or R.F.D. No / City or Town / County / State: Rr. Tak. Pk. Academy, T.P. Montgomery Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D

EXAMINER'S NAME (Type): Belden R. Reap, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (City, town, or county): Rockville

22b DATE SIGNED: April 24, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 4/28/69	23c NAME OF CEMETERY OR CREMATORY: Flint Hill	23d LOCATION (City or Town) (County) (State): Oakton, Virginia
24. FUNERAL DIRECTOR: M. Eichenberger	ADDRESS: Money & King Vienna Funeral Home Vienna, Va.	25a RECD BY REGISTRAR DATE: APR 28 1969	25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV 1/68

Item15 FilmG412
5/2/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05752

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certif cate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with for Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First: JESSE	Middle: JAMES	Last: SWEAT	JR		
2a. DATE KNOWN OF DEATH ESTIMATED	Month: APR	Day: 17	Year: 1969	2b. HOUR: 145PM		
3. SEX: MALE	4. RACE: CAUC	5. DATE OF BIRTH: OCT 21, 1952	6. AGE (in years last birthday): 16 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
2c. DATE PRONOUNCED DEAD	Month: APR	Day: 17	Year: 1969	2d. HOUR: 145PM		
7a. BIRTHPLACE (State or foreign country): FLORIDA	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED / NEVER MARRIED XX / WIDOWED / DIVORCED	9. COUNTY OF DEATH: MONTGOMERY Md			
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): NAVAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): STUDENT	12b. KIND OF BUSINESS OR INDUSTRY: N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: VIRGINIA	13b. COUNTY: PRINCE WILLIAMS	13c. CITY OR TOWN: WOOD-BRIDGE	13d. INSIDE CITY LIMITS? YES / NO X	13e. STREET AND NUMBER: 841 HALIFAX RD		
14. FATHER'S NAME First / Middle / Last: JESSE JAMES SWEAT Sr	15. MOTHER'S MAIDEN NAME First / Middle / Last: Iris LULA/ Gwendolyn PARRISH Dicks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT ADDRESS: HOSPITAL RECORDS				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Laceration, maceration of brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours
1954
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): gunshot wound to head (self-inflicted)
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES / NO X
21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING / CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.: 6:00 P.M Apr 16 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Shot self in head 22 caliber rifle
21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK X	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: 841 Halifax Rd. / Woodbridge, Pr. Wm. / Va.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide X, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D.
EXAMINER'S NAME (Type): John G. BALL, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
ADDRESS (Street, city, town or county):
22b. DATE SIGNED: 18 April 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 21 Apr. 69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION (City or Town) (County) (State): Arlington / Arlington / Va.
24. FUNERAL DIRECTOR: Cunningham Mountcastle ADDRESS: Woodbridge, Virginia B East Mountcastle	25a. REC'D BY REGISTRAR DATE: APR 23 1969	25b. REGISTRAR'S SIGNATURE: William Jessup	

VR A15ME (5)
10M REV 1 68

Items 18-22a Film 412
5-12-69 ams

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05753

1 DECEASED NAME (Type or Print)	First: Miyako	Middle: C	Last: Taketa	2a DATE KNOWN OF DEATH ESTIMATED ☒	Month: 4	Day: 29	Year: 1969
2b HOUR	10:45 A.M.						
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD	2d HOUR
Fe	Japanese	Jan 15, 1909	60 YRS.			Month: April Day: 29 Year: 1969	10:59 A.M.
7a BIRTHPLACE (State or Foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH				
Washington	U.S.A.		Montgomery Md				
10. CITY OR TOWN OF DEATH	NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)	12b KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban.	Housewife	Own home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER			
Maryland	Montgomery	Kensington	YES ☒ NO ☐	11212 Woodson Avenue			
14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last		
Shinjiro	-	Okada	Yone	-	Tange		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS			
No		Yes 268-24-1698	Husband Chiyoto Taketa.	Same			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Barbiturate poisoning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ½ hr.
1860
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Overdose of barbiturate
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	8:30 P.M. 4/29 1969	Took overdose of barbiturate
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State
	Home	1112 Woodson St. Kensington Mont. Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county):
22b DATE SIGNED: April 29, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	May 2, 1969	Fort Lincoln Crematory	Bladensburg, Maryland
24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Glen C. Glen Carter Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Maryland	MAY 5 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)
10M REV 1-68

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

.05759

CERTIFICATE OF DEATH

05754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Florence	Middle: LaRue	Last: Tankersley	2a. DATE OF DEATH: April Month 8 Day 1969 Year
2b. HOUR: 315 M	3. SEX: Female	4. RACE: White - Caucasian	5. DATE OF BIRTH: 1-10-93
6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): PENN.	7b. CITIZEN OF WHAT COUNTRY?: America	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): None HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: D.C.	13b. COUNTY	13c. CITY OR TOWN: Wash., D.C.	13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 1905 13th St., N.W.			
14. FATHER'S NAME First: Thomas	Middle	Last: Mitchell	15. MOTHER'S MAIDEN NAME First: Minnie Middle	Last: Adams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown): No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): ~~227-05-9563~~ Unknown	17. INFORMANT: Thomas M. Giffings Jr. Address: Patient's chart	806-15th St., N.W. 520 Shoreham Bldg., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Stroke. — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 12 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Upper gastrointestinal hemorrhage — 3½ days
DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral arteriosclerosis — 1 month
531.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Intermittent heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from Oct. 1960, to Apr. 8 1969, that (I) ~~(we)~~ last saw the deceased alive on Apr. 7 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death

22b. SIGNATURE: Serusch T. Kimble, M.D.	DEGREE: ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 4-8-69.	
22d. PHYSICIAN'S NAME (Type): Serusch T. Kimble	22e. ADDRESS: 9801 Georgia Ave, Silver Spring		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: April 11, 1969	23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Mausoleum	23d. LOCATION (City or Town) Washington, D. C. (County) (State) Md.
24. FUNERAL DIRECTOR: C. Glen Carter, Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Avenue Silver Spring, Md.	25a. RECD. BY REGISTRAR DATE: APR 11 1969	25b. REGISTRAR'S SIGNATURE: Deputy Judge

VR A15 (M)
45M - 11-69

Items 18-22a Film 412
5-8-69 ams

Items 16a,b,FilmC 412

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05755

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	2b HOUR
JAMES 05760	Charles	TAYLOR	Month 4 Day 18 Year 69	7:40 PM

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c DATE PRONOUNCED DEAD	2d HOUR
M	WH	1/7/29	40 YRS			Month 4 Day 18 Year 1969	7:40 PM

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Wash., DC	USA	MARRIED X	Montgomery Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring., Md.	Holy Cross Hospital	Research Engineer Technical Staff	Communications & Systems, Inc

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Sil. Spring	YES X NO	1545 N. Falkland Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES	E.	TAYLOR	Agnes	E.	Beveridge

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes no	yes	Marilyn Taylor (wife) Silver Spring, Maryland 1545 N. Falkland Lane

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Gunshot wound of head,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) self-inflicted

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES X NO

21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
CAUSE OF DEATH	7:30 P.M. 4-14 1969	Deceased, depressed, shot self in forehead.

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK X	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Home		Silver Spring	Montg.	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide X, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden K. Reap M.D.

EXAMINER'S NAME (Type) BELDEN K. REAP M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS (Street, city, town, or county) Forestville

22b. DATE SIGNED APRIL 18, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 21, 1969	Colesville Cemetery	Colesville, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Carter Colesville Chapel Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil. Spg.	Maryland	APR 22 1969	Charles Yeager

VR A15ME (5
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05761 05756

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARGARET	EITTA	TAYLOR	APRIL 12, 1969	10:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	Caucasian	9/27/1886	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Utah	USA		Montgomery Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	5620 McLean Drive	Homemaker	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Montgomery	Bethesda		5620 McLean Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Ellsworth	Isabell		Morris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	unknown	(daughter) Mrs. F. Price Merrels	5609 Wilson Lane Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Mo.
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Breast — 3 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174.1

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from MARCH, 1966, to APRIL 12, 1969, that (I) (we) saw the deceased alive on APRIL 11 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Peyton R Evans Jr M.D.					April 12, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Peyton R. Evans, Jr., M.D.	4900 Massachusetts Ave., N. W., Wash., D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	4/15/69	Cedar Hill Crematory	Suitland, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc., Washington, D. C.	APR 15 1969	Miranda Judge

VR A15 Y4
45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05762

05757

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Virginia	Middle: Isabelle	Last: Taylor	2a. DATE OF DEATH: Month Apr, Day 17, Year 1969
2b. HOUR: 6:51 A M			
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: Aug 11, 1910	6. AGE (Last birthday): 58 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Mass.	7b. CITIZEN OF WHAT COUNTRY?: USA.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): housewife	12b. KIND OF BUSINESS OR INDUSTRY: —
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Dist of Col.	13b. COUNTY: —	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: 6605-32nd St. N.W.			
14. FATHER'S NAME First: John	Middle	Last: McCarg	15. MOTHER'S MAIDEN NAME First: Gertrude Middle: — Last: Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Frank Taylor - husband (Address): 6605-32nd St. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis, acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary arteriosclerosis, severe — years.
DUE TO, OR AS A CONSEQUENCE OF
(c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4107

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 7/11, 19 68, to 3/28, 19 69, that (I) (we) last saw the deceased alive on 3/28 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen W. Dejter — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]		22c. DATE SIGNED: 4-17-1969
22d. PHYSICIAN'S NAME (Type): Stephen W. Dejter	22e. ADDRESS: 6719 Wilson Lane Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-21-1969	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State): Arlington County, Virginia	
24. FUNERAL DIRECTOR ADDRESS: JOSEPH GAWLER'S SON, INC.		25a. RECD BY REGISTRAR DATE: APR 23 1969	25b. REGISTRAR'S SIGNATURE: Winnifred Gardner	

VR A 5 (4) 45M - 1/69

Item23c FilmG413 6/23/69kk

05763

Items#1,5,16,17, FilmG413 6/2/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ESTHER	PENELOPE	THOMPSON	APRIL	17	1969	6:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
FEMALE	CAUC	23 NOVEMBER 1928	40 30 YRS.	4	24		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
NEW YORK	USA		MONTGOMERY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL, BETH, MD	TECHNICIAN-BIO SCI	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD		LANHAM	YES [X] NO [ ]	9310 ORBIT LANE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH	A.	Profeta PROFUTA	MARIE		DELROSSO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		Profeta J. PROFUTA	S. AZONE PARK 123-11 150th AVE QUEENS N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MASSIVE SUBARACHNOID HEMORRHAGE

4309

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (X) (this hospital) attended the deceased from 14 APR, 1969, to 17 APR, 1969, that (X) (we) last saw the deceased alive on 17 APRIL 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Evans Diamond M.D.				[X]	18 APRIL 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
EVANS DIAMOND MD	NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	4-22-69	Cypress Hills Cemetery EVERGREEN CEMETARY	QUEENS		N.Y.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
7557 WISCONSIN AVE. ROBERT A. PUMPHREY FUNERAL HOME BETH MD.	APR 23 1969	Charles Judge

VR A15 (4) 30M REV 1/68

1

05764

Item23 Film6412 4/30/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05759

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: Clarence	Middle: Willard	Last: Tibbs	2a. DATE OF DEATH: Apr Month 17th Day 69 Year
2b. HOUR: 6.50 AM			
3. SEX: Female	4. RACE: White	5 DATE OF BIRTH: May 24th 1915	6 AGE (In years last birthday): 53 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a BIRTHPLACE (State or foreign country): Nebo. Va.	7b CITIZEN OF WHAT COUNTRY?: U S A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Montg, Md. Md
10 CITY OR TOWN OF DEATH: Rt 2.Germantown. Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt 2. Germantown.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Md House wife	12b KIND OF BUSINESS OR INDUSTRY: H
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY	13c CITY OR TOWN: Germantown	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e STREET AND NUMBER			
14. FATHER'S NAME First: Henry	Middle:	Last: Cox	15. MOTHER'S MAIDEN NAME First: Sarah	Middle:	Last: Tibbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: Claud A. Tibbs.	Address: Germantown. Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b): Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a I certify that (I) (this hospital) attended the deceased from 10-23, 19 38, to ____, 19 ____, that (I) (we) last saw the deceased alive on ____ 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

22b SIGNATURE: Milton D. Westberg M.D.	DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 4-18-1969	
22d PHYSICIAN'S NAME (Type): Milton D. Westberg, M.D.	22e ADDRESS: 431 N. Frederick Ave., Gaithersburg, Md.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: April 19,1969	23c NAME OF CEMETERY OR CREMATORY: Memorial Haven	23d. LOCATION (City or Town): Frederick.Co.	(County) (State): Md.
24. FUNERAL DIRECTOR: Ernest C. Gartner	ADDRESS: Gaithersburg. Md.	25a REC'D BY REGISTRAR DATE: APR 21 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A1 5(A) 30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05765

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First: PHILLIP	Middle	Last: TIPPERMAN	2a DATE OF DEATH KNOWN ☒ / ESTIMATED ☐	Month: 4	Day: 11	Year: 69	2b HOUR: 6:36 PM
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: 12-25-16	6 AGE (In years last birthday): 52 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 4 Day 11 Year 1969		2d HOUR: 6:36 PM	
7a BIRTHPLACE (State or foreign country): N.Y.	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Montgomery Md						
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Mont.	13c. CITY OR TOWN: Rockville	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 5110 Yosemite Dr.					
14. FATHER'S NAME First / Middle / Last: Benjamin Tipperman	15. MOTHER'S MAIDEN NAME First / Middle / Last: Eva Finkelstein								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: Milton Tipperman, 5110 Yosemite Dr.	ADDRESS: Rockville, Md.						

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Asphyxiation due

DUE TO, OR AS A CONSEQUENCE OF (b): to hanging, self-

DUE TO, OR AS A CONSEQUENCE OF (c): inflicted

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 4-11 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18): Lodged, depressed, changed self from door frame.
21d INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Bldg.	21f LOCATION (Street or R.F.D. No. / City or Town / County / State): 1055 Ripley St. S.S. Montgom. Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): Belden R. Reap, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, Town or County): Rockville

22b DATE SIGNED: April 11, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE: 4/13/69	23c. NAME OF CEMETERY OR CREMATORY: KING DAVID Mem. Garden	23d. LOCATION (City or Town) (County) (State): FALLS CHURCH Va.
24. FUNERAL DIRECTOR: B. Daugherty & Sons	ADDRESS: 3501 - 14th St. WASH. D.C.	25a. REC'D BY REGISTRAR DATE: APR 16 1969	25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05766 05766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Madeline; Middle: ; Last: Tonelli	2a. DATE OF DEATH Month: April; Day: 15; Year: 1969	2b. HOUR: 9 20 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: October 12, 1904	6. AGE (In years last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Italy	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): house wife	12b. KIND OF BUSINESS OR INDUSTRY: own home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 9509 Midwood Road
14. FATHER'S NAME First: Jerome; Middle: ; Last: Simonutti	15. MOTHER'S MAIDEN NAME First: Anna; Middle: (unknown); Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: -- (If yes give war or dates of service): --	16b. SOCIAL SECURITY NO: 079-06-0611	17. INFORMANT: Mr. Peter Tonelli	Address: Silver Spring, Md 9509 Midwood Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INCREASED INTRACRANIAL PRESSURE
DUE TO, OR AS A CONSEQUENCE OF (b): CEREBRAL HEMMORHAGE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): HYPERTENSIVE CARDIOVASCULAR DISEASE — 4 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) —	21f. LOCATION Street or R.F.D. No. — City or Town — County — State	

22a. I **certify** that (I) (this hospital) attended the deceased from 4-11, 1969, to 4-15, 1969, that (I) (we) last saw the deceased alive on 4-14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis C Mayle Jr MD — DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 4-16-69

22d. PHYSICIAN'S NAME (Type): FRANCIS C MAYLE JR MD — 22e. ADDRESS: 8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: April 19, 1969	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State): Silver Spring, Mont., Md.	
24. FUNERAL DIRECTOR: Paul J. Smith of Smith & Knight Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Avenue Silver Spring, Md.	25a. RECD BY REGISTRAR DATE: APR 22 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15(4) 30M REV (69)

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05767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item23 FilmG411 4/14/69 kk

CERTIFICATE OF DEATH

0576

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
Rebecca	Kay	Toney	April 5 1969	11:25 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	20 July 1963	5 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Virginia	USA	NEVER MARRIED ☒	Montgomery Md.

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Child	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Virginia	Prince William	Manassas Park	YES ☒ NO ☐	141 Colburne Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jack	E.	Toney	Deanna		Meadows

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		None	Bethesda, Md. 20014 The Medical Records, The Clinical Center	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory failure	5 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Systemic Candidiasis	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute Lymphocytic Leukemia	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 204.0

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
☐ OR CONTR BUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1 December 1960, to 5 April, 19 69, that (I) (we) last saw the deceased alive on 5 April 19 69 and that to the (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert E. Gallagher, M.D.		☐	☐	☒	6 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert E. Gallagher, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	April 8 69	Stonewall Memory	Manassas, Virginia.

24. FUNERAL DIRECTOR	ADDRESS	25a FILED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Baker Funeral Home Gilbert Baker	Manassas, Va.	APR 10 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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05768

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05768

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
William	Henry	Towns	April	28	1969	9:10 A M

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	Negro	12 September 1913	55 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
North Carolina	USA		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Laborer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER
Washington, D.C.		Washington, D.C.		3907 Illinois Avenue, NW

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Matthew	Towns	Henrietta		Davis

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	237-03-4087	Bethesda, Maryland The Medical Records, The Clinical Center,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure with probable Right Middle Lobe Pneumonia	2 Weeks
DUE TO, OR AS A CONSEQUENCE OF (b)	Cryptococcosis	2 Weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Sezary Syndrome, and Mycosis Fungoides	4 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 116.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that ☒ (this hospital) attended the deceased from 7 April, 1969, to 28 April, 1969, that ☒ (we) last saw the deceased alive on 28 April 1969, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Peter J. Rosen M.D					30 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Peter J. Rosen, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-2-69	Harmony Cemetery	Landover, Md.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W.W. Chamblin Co 1400 Chapin St. NW Washington, DC.	MAY 5 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR ATS (A) 30M REV 1/68

Item7 FilmGh14 7/1/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05769 — 05764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Edythe	Middle: Margaret	Last: Turner	2a. DATE OF DEATH Month: April	Day: 28,	Year: 1969	2b. HOUR: 6:00PM
3. SEX: Female	4. RACE: White	5 DATE OF BIRTH: 9-17-92	6 AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): Minnesota Indiana	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.				
10 CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Teacher Home Demo, Agent	12b KIND OF BUSINESS OR INDUSTRY: State of Md.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Mont.	13c CITY OR TOWN: Takoma Park	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 7710 Maple Ave.,			
14 FATHER'S NAME First: David	Middle: H.	Last: Turner	15 MOTHER'S MAIDEN NAME First: Elizabeth	Middle: -	Last: Bohrer		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 031-28-8652	17 INFORMANT: May C. Turner - Address: 7710 Maple Ave., Takoma Park Md.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c)) Old ant. & post. infarction

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Congestive Failure & Pneumonitis — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 1 day

4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis & Diabetes Mellitus, Gall Stones

DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral Vascular Disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19 5 L, to April 28, 19 69, that (I) (we) last saw the deceased alive on April 28, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE - E. H. Horton, M.D. DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED: 4/28/69

22d. PHYSICIAN'S NAME (Type): Chas H. Wilson — 22e ADDRESS: 831 Univ. Blvd. E., Silver Spring, Md.

23a BURIAL, CREMATION, REMOVAL: Burial	23b DATE: May 2, 1969	23c NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery	23d LOCATION (City or Town) (County) (State): Crookston, Minnesota
24a FUNERAL DIRECTOR: C. Glen Carter	ADDRESS: 8434 Georgia Avenue	25a RECD BY REGISTRAR DATE: MAY 2 1969	25b REGISTRAR'S SIGNATURE: [signature]
Warner E. Pumphrey, Inc.	Silver Spring, Md.		

VR A 5 14
45M 1/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05770

05765

1. DECEASED-NAME (Type or print) First: Russell; Middle: ; Last: ULDRICK	2a. DATE OF DEATH Month: APRIL; Day: 22; Year: 1969	2b. HOUR: 1220 AM	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: Apr. 21, 1969	6. AGE (In years last birthday): — YRS. IF UNDER 1 YEAR: MONTHS: ; DAYS: IF UNDER 24 HRS.: HOURS: 10; MIN.:
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A
13a. USUAL RESIDENCE (Where deceased lived, if nstitution: Res dence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Kensington	13d. INSIDE CITY LIM TS? YES ☐ NO ☒	13e. STREET AND NUMBER: 10108 Thornwood Road
14. FATHER'S NAME First: Thomas; Middle: S.; Last: Uldrick	15. MOTHER'S MAIDEN NAME First: Lucille; Middle: ; Last: Brazil		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT Address: Kensington, Md. Mr. Thomas S. Uldrick, 10108 Thornwood Rd.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7769
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTR BUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.	21f. LOCATION Street or R.F.D No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Apr. 21, 1969, to Apr. 22, 1969, that (I) (we) last saw the deceased alive on Apr. 22, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gary H. Safley, M.D. DEGREE	ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: Apr. 23, 1969	
22d. PHYSICIAN'S NAME (Type): GARY H. SAFLEY, M.D.	22e. ADDRESS: Naval Hospital, Bethesda, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-28-69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION (City or Town): Arlington	(County): Arlington (State): Va.
24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Funeral Home 7557 Wisconsin Ave., Bethesda, Md.	25a. REC'D BY REGISTRAR DATE: MAY 5 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05771

CERTIFICATE OF DEATH

05766

1. DECEASED-NAME (Type or print) First: Donna	Middle: Marie	Last: UNDERWOOD	2a. DATE OF DEATH: April (Month) 27 (Day) 1969 (Year)	2b. HOUR: 6:30 AM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH: 26 April 1969	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 18 / MIN 29
7a. BIRTHPLACE (State or foreign country): Maryland-AA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.	
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 13009 Wilton Oaks Drive
14. FATHER'S NAME First: DEWEY	Middle: L.	Last: UNDERWOOD	15. MOTHER'S MAIDEN NAME First: BARBARA MARIE	Middle: THOMPSON	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Father: DEWEY L. UNDERWOOD,	Address: 13009 Wilton Oaks Drive Silver Spring, Md. 20902	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Neonatal Hepatitis with Hydrencephaly — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

0795

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cytomegalic Inclusion disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (☒ (this hospital) attended the deceased from 26 April, 19 69, to 27 April, 19 69, that (☒ (we) last saw the deceased alive on 27 April 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED: 28 April 1969

22d. PHYSICIAN'S NAME (Type): G. H. SAYLEY LT MC USN — 22e. ADDRESS: NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 1, 1969	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.	23d. LOCATION (City or Town) (County) (State): Arlington, Virginia	
24a. FUNERAL DIRECTOR: W. E. PUMPHREY FUNERAL HOME, 8434 Georgia Ave., Silver Spring, Md.	24b. ADDRESS: Colen Carter	25a. REC'D BY REGISTRAR DATE: MAY 5 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1-68

1

05772

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05767

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Robert Middle: G. Last: VanVranken				2a. DATE OF DEATH Month: April Day: 20 Year: 69	2b. HOUR: 1:55 P.M.
3. SEX: M	4. RACE: Cau	5. DATE OF BIRTH: 5/1/98	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): D. C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md		
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Real Estate	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Mont.	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 7601 Fountain Ct.	
14. FATHER'S NAME First Middle Last: Fred Van Vranken		15. MOTHER'S MAIDEN NAME First Middle Last: Elizabeth Cain			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service): No.	16b. SOCIAL SECURITY NO: 577-10-7039	17. INFORMANT: Martha Van Vranken	Address: Home of wife		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): METASTATIC CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Months
DUE TO, OR AS A CONSEQUENCE OF (b): PRIMARY CARCINOMA of COLON — 3-Y Mos.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 1/15/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: CARCINOMA of COLON	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from JAN, 1957, to APL, 1969, that (I) (we) last saw the deceased alive on APRL 19 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 4/20/69
22d. PHYSICIAN'S NAME (Type): ORLAN I DONOVAN
22e. ADDRESS: 8211 WISCONSIN AVE BETHESDA

23a. BURIAL CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 4-21-1969	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Prince Georges Co. Md	
24. FUNERAL DIRECTOR: JOSEPH GAWLER'S SON, INC. ADDRESS: 5190 WISC. AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR: APR 23 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15 (4)
45M - 1/69

1

05773

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05768

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no appr event, within 72 hours after death.

VR A15(4)
30M REV 1-68

1 DECEASED-NAME (Type or print)	First: John	Middle: William	Last: Vernon	2a. DATE OF DEATH: Month: April Day: 11 Year: 1969	2b HOUR: 5:50 AM
3 SEX: Male	4 RACE: White	5. DATE OF BIRTH: June 23, 1909	6 AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): District of Col.	7b. CITIZEN OF WHAT COUNTRY?: America	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.		
10 CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San + Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Painter	12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 16530 Emory Lane	
14 FATHER'S NAME First: John	Middle:	Last: Vernon	15. MOTHER'S MAIDEN NAME First: Lula	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): WWII	16b SOCIAL SECURITY NO: 578-26-3009	17. INFORMANT: Grace H. Riley	Address: Rockville, Md. 16530 Emory Lane	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5½ days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis of left internal carotid artery — 5½ days
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 8/4, 1965, to April 11, 1969, that (I) (we) last saw the deceased alive on April 10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip E. Jones M.D. DEGREE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 4/11/69	
22d. PHYSICIAN'S NAME (Type): Philip E. Jones MD	22e ADDRESS: 800 Pershing Drive Silver Spring, Md. 20910		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: April 14, 1969	23c. NAME OF CEMETERY OR CREMATORY: Washington National Cem	23d LOCATION (City or Town): Suitland, Maryland	(County) (State)
24 FUNERAL DIRECTOR: Carter Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Avenue Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE: APR 17 1969	25b REGISTRAR'S SIGNATURE: [illegible] Deputy Judge	

1

05774

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0576

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then p ease remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: BERTHA	Middle: L.	Last: Waldron xxxxxxxxxx	2a. DATE OF DEATH Month: 4	Day: 13	Year: 69	2b. HOUR: 9:30 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: April 11, 1875	6. AGE (in years last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY		Md
10. CITY OR TOWN OF DEATH: Burtonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 3408 Greencastle Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admiss on) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Burtonsville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 3408 Greencastle Road		
14. FATHER'S NAME First: August	Middle:	Last: Erdmann	15. MOTHER'S MAIDEN NAME First: Henriette	Middle:	Last: Erdmann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 220-44-8097	17. INFORMANT: MARY L CUNNINGHAM xxxxxxxxxx	Address: 910 Halbarn St.	SS No.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): MYOCARDIAL Infarction.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease.

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTR BUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept 1, 1967, to April 13, 1969, that (I) (~~we~~) last saw the deceased alive on April 21, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Burton A. Johnson, M.D.	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	4-13-69
22d. PHYSICIAN'S NAME (Type) Burton A. Johnson	22e. ADDRESS 4140 Sandy Springs Rd, Burtonsville.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 16, 1969	Ft. Lincoln Cemetery	Bladensburg, Maryland

24. (FUNERAL DIRECTOR)	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glenn Carter Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.	APR 17 1969	Charles Judge

VR AIS 14
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05775 — 05770

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: VIVIAN Middle: S. Last: WALSH
2a. DATE OF DEATH Month: 4 Day: 3 Year: 69
2b. HOUR M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 12/22/17
6. AGE (In years last birthday): 51 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country): NEB.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE: Md.
13b. COUNTY: ~~Montgomery~~ Prince Georges
13c. CITY OR TOWN: Beltsville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 3129 Fallston AVE
14. FATHER'S NAME First: Samk Middle: Last: Sander
15. MOTHER'S MAIDEN NAME First: Eva Middle: Last: Spukerman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: Yes
17. INFORMANT: John J. Walsh ADDRESS: 3129 Fallston Avenue Beltsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Adenocarcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ~~several~~ 1 MOS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Adenocarcinoma of Ovary — 14 mos
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Thrombocytopenia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No City or Town County State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/28, 1968, to 4/3, 1969, that (I) ~~(we)~~ last saw the deceased alive on 4/3 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.
22b. SIGNATURE: G. Lennard Gold DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 4/4/69
22d. PHYSICIAN'S NAME (Type): G. Lennard Gold
22e. ADDRESS: 9801 Georgia Avenue, Silver Spring, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: April 4, 1969
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
23d. LOCATION (City or Town) (County) (State): Prince Georges County, Md.
24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: APR 1 7 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05776

CERTIFICATE OF DEATH

05771

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Charles	Allen	Walters	April	14,	1969	11:29 P

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Male	White	3 January 1928	41 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
North Carolina	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Carpenter	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
North Carolina	V	Hope Mills	YES ☐ NO ☒	Route 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Barney		Walters	Maude		Maggs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No	242-40-2126	The Medical Record	The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1121

DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Malignant Melanoma — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D No.	City or Town	County	State

22a. I certify that (X) (this hospital) attended the deceased from 12 April, 1969, to 14 April, 1969, that (X) (we) last saw the deceased alive on 14 April 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Everett V. Sugarbaker M.D.					15 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Everett V. Sugarbaker, M.D.	The Clinical Center, National Institutes of Health, Bethesda Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-1969		RED SPRINGS, N.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. FILED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co	1402 Chapin St NW Wash DC	APR 25 1969	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05777

CERTIFICATE OF DEATH

05772

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Andre'	David	Walther	April	23,	1969	5:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	20 August 1960	8 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Iowa	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Student	

13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Iowa		Cedar Falls		1809 West Ridgewood Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Andre'	Gaston	Walther	Wyatte		Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
no	NONE	The Medical Record	The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Burkitt's Lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1 April, 1969, to 23 April, 1969, that (I) (we) last saw the deceased alive on 23 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Sherrard L. Hayes MD	MD				24 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sherrard L. Hayes, MD.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	5-21-69	SOULAC CEMETERY	GIRONDE FRANCE

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
H.W. Chambers Co	8655 GA AVE SILVER SPRING MD	MAY 1 1969	Richard Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05778

CERTIFICATE OF DEATH

05775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Alec	Robert	WATSON	April	9,	1969	8:45 P.M.

3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	CAUCASIAN	APR. 9, 1969	— YRS.				15

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	Holy Cross Hospital		

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	A. Arunde	Crofton	YES ☐ NO ☒	1704 Spring Green Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	W	WATSON	Mary Jean.		Sweeney Watson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT Address
		James W. Watson-father

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Failure to Expand Lungs — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immed
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Low lying Placenta, Cord around neck

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
Donald Levitt M.D.		☐	☒	☐	4/9/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Donald Levitt M.D.	3233 Superior Ave. Bowie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/12/69	Gate of Heaven Cem.	Silver Spring, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland	APR 15 1969	Charles Owens

VR A15 (4) 30M REV 1/69

Items 18&22a Film 412 5-12-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05774

FOR STATE HEALTH DEPT.

1 DECEASED NAME (Type or Print) First: Charles	Middle: Wheeler	Last: Weaver	2a. DATE KNOWN OF DEATH ☐ EST. ☒ Month: 4	Day: 12	Year: 1969	2b HOUR: 11:30 A.M.
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: Nov 6 1954	6 AGE (In years last birthday): 14 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: April Day: 12 Year: 1969	2d HOUR: 11:35 A.M.
7a BIRTHPLACE (State or foreign country): Wash DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Montgomery Md				
10. CITY OR TOWN OF DEATH: Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md	13b COUNTY: Mont	13c CITY OR TOWN: C. Ch.	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER: 6922 Woodside Pl.			
14. FATHER'S NAME First: Charles	Middle: L.	Last: Weaver	15 MOTHER'S MAIDEN NAME First: Margaret	Middle:	Last: Lomax		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT: Father - Chas L Weaver	ADDRESS: Same as 13e			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Encephalitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.?
DUE TO, OR AS A CONSEQUENCE OF
(b) Viral infection
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 7 7 7

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Pneumonitis - Viral

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No. / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Ball M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: April 13, 1969

EXAMINER'S NAME (Type): John G. Ball ADDRESS (Street or R.F.D., Town, or County): 7936 Old Georgetown Road Bethesda, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	4/14/69	Cedar Hill	Prince George's County Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home ADDRESS: 1391 Rock. Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: APR 15 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M REV 1/68

05780

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#6, Film G411 4/18/69 km

CERTIFICATE OF DEATH

05775

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR		
NYLA	C.	WEBB	APRIL	9	1969	0140	M	

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
FEMALE	CAUC	05 SEPT 1913	55 56 YRS	6	8	1	40

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Ohio	U.S.A.		MONTGOMERY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	Housewife	

13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE	COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Pennsylvania		Selins Grove	YES [ ] NO [X]	Hoover's Trailer Park

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Unknown			Hazel		Putt

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	224-28-9168	Hospital records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Carcinoma breast with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (X) (this hospital) attended the deceased from 31 MAR, 19 69, to 9 APR, 19 69, that (X) (we) last saw the deceased alive on 9 APRIL 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [ ]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c DATE SIGNED
[signature]					9 April 1969

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
M. D. GORMAN M. D.	Naval Hospital, Bethesda, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4-11-69	Westside Cemetery	Selins Grove		Penn.

24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.	APR 15 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4) 45M 1/69

1

05781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Mabel Elizabeth Webster; Middle; Last
2a. DATE OF DEATH: Month 4 Day 8 Year 69
2b. HOUR: 10 05 AM
3. SEX: Female
4. RACE: Negro
5. DATE OF BIRTH: 8/9/1892
6. AGE (In years last birthday): 76 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min
7a. BIRTHPLACE (State or foreign country): Va.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Wheaton, Md.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): University Nurs. Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Clerk
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Washington, DC
13b. COUNTY: V
13c. CITY OR TOWN:
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1811 Vernon St., NW
14. FATHER'S NAME First: Marshall Wanser; Middle; Last
15. MOTHER'S MAIDEN NAME First: Martha Foultz; Middle; Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 578-66-6001
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIO SCLEROTIC CARDIO VASCULAR
DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M P.M Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from NOV, 19 68, to APRIL, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 7 APR 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (.) ~~(we)~~ (did) ~~(did not)~~ view the body after death

22b. SIGNATURE: [signature] MD DEGREE ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 8 April 69
22d. PHYSICIAN'S NAME (Type): Walter Goozh, M.D.
22e. ADDRESS: 2309 Shorefield Rd., Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/12/1969
23c. NAME OF CEMETERY OR CREMATORY: Local
23d. LOCATION (City or Town) (County) (State): Catlett, Virginia

24. FUNERAL DIRECTOR: W. E. Jarvis & Son
ADDRESS: 1432 You N.W.
25a. RECD BY REGISTRAR DATE: APR 14 1969
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 30M REV. 1/68

1

05782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05777

Cleared with Medical Examiner/ls

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	SAM WEINER	2a. DATE OF DEATH Month / Day / Year	April 3, 1969	2b. HOUR 9:00p M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	May 15, 1886	6. AGE (In years last birthday)	82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	Russia	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH	Montgomery Md
10. CITY OR TOWN OF DEATH	Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	Md.	13b. COUNTY	Mont.	13c. CITY OR TOWN	SilverSpring	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER	518 Lamberton Dr.
14. FATHER'S NAME First / Middle / Last	Max Weiner	15. MOTHER'S MAIDEN NAME First / Middle / Last	Judith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	None	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO	076-28-3169-A	17. INFORMANT	Mr. Max Weiner, as above	Address: Son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4-6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan, 1968, to Apr 3, 1969, that (I) (~~we~~) last saw the deceased alive on Apr 1st 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	R.H. Sandstrom MD	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐	22c. DATE SIGNED 4/7/69
22d. PHYSICIAN'S NAME (Type)	R.H. Sandstrom MD	22e. ADDRESS	7701 Carroll Av Takpk, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	April 6, 1969	Beth David Cemetery	Elmont, New York	
24. FUNERAL DIRECTOR	Donald M. Stein	ADDRESS	232 Carroll St., N.W. Wash., D.C.	25a. RECD BY REGISTRAR DATE APR 7 1969
Hebrew Memorial Funeral Home				25b. REGISTRAR'S SIGNATURE [illegible] Judge

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05783

CERTIFICATE OF DEATH

05778

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Llewellyn	Middle Hopkins	Last Welsh
2a. DATE OF DEATH Month Day Year	APRIL 26 1969	2b. HOUR	6 17 A M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	Nov. 1, 1912		
6. AGE (In years last birthday)	56 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	Washington DC		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	Montgomery		Md.
10. CITY OR TOWN OF DEATH	Bethesda		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SUBURBAN HOSP.		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Research Chemist		
12b. KIND OF BUSINESS OR INDUSTRY	Food + Drug Adm		
13a. USUAL RESIDENCE (Where deceased lived, before admission) STATE	MARYLAND		
13b. COUNTY	Montgomery		
13c. CITY OR TOWN	Bethesda		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	6302 Valley ROAD.		
14. FATHER'S NAME First	Abner	Middle H.	Last Welsh
15. MOTHER'S MAIDEN NAME First	Rose	Middle —	Last Greer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO	215-44-8363		
17. INFORMANT Address	Wife - Betty D.	Above	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Coronary Insuff

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from February, 1968, to 4-26, 1969, that (I) ~~(we)~~ last saw the deceased alive on March 26, 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	Stephen W. Dejter, M.D.	DEGREE ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED 4-26-69
22d. PHYSICIAN'S NAME (Type)	STEPHEN W. DEJTER, M.D.	22e. ADDRESS	6719 WILSON LANE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
BURIAL	4-29-69	PARKLAWN CEM.	ROCKVILLE, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
JOS. GAWLER'S SONS,	5130 WIS. AVE. NW WASHINGTON, D.C.	MAY 2 1969	Charles Judge	

VR A15-14
45M - 1-69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05784 05779

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
Sam	Bud	Werner	April 30 1969	5:05 A M

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	11 August 1934	34 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
New Jersey	USA		Montgomery Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center	Newspaperman	Newspaper

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER
Virginia		Arlington		111 North Edgewood Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Eugene	A.	Werner	Lillian		Band

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
Yes	1958	141-26-4518	The Medical Records	The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrhythmia	1 hour
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Postoperative myocardial revascularization	12 hours
DUE TO, OR AS A CONSEQUENCE OF		
(c)	Severe coronary artery disease and left ventricular scarring	7 years

4125

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC	21f LOCATION Street or R.F.D No.	City or Town	County	State

22a. **I certify** that (X) (this hospital) attended the deceased from 27 April, 1969, to 30 April, 1969, that (X) (we) last saw the deceased alive on 30 April 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS ☒	22c DATE SIGNED
Bradley M. Rodgers					30 April 1969

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
Bradley M. Rodgers, M.D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5-1-1968	Mt. Lebanon Cemetery	Iselin New Jersey

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Goldberg Funeral Home 4217 9th Street N.W.	MAY 1 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05785 Items5&6 Film6412 5/9/69 kk

CERTIFICATE OF DEATH

05780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Kathleen	Middle: French	Last: White	2a. DATE OF DEATH: April 24	69
2b. HOUR	8 P.M.				
3. SEX	F	4. RACE	Cau.	5. DATE OF BIRTH	3-4-1875
6. AGE (In years last birthday)	94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M.N		
7a. BIRTHPLACE (State or foreign country)	Ireland	7b. CITIZEN OF WHAT COUNTRY?	U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	Montgomery Md				
10. CITY OR TOWN OF DEATH	Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Kensington Gardens	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	Md.	13b. COUNTY	Mont	13c. CITY OR TOWN	Chevy Chase
13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER	3351 Jones Bridge Rd.			
14. FATHER'S NAME First / Middle / Last	Thomas / French	15. MOTHER'S MAIDEN NAME First / Middle / Last	Catherine / Forbes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	no	16b. SOCIAL SECURITY NO	579206769	
17. INFORMANT	Mr. Maurice Keane	Address	2234 California Ave.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intestinal hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

E499

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Generalized arteriosclerosis

19a. DATE OF OPERATION	None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 8/24, 19 68, to 4/24, 19 69, that (I) (we) last saw the deceased alive on 4/22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	John B. Umhau	M.D. DEGREE	ATTENDING PHYS. ☑	MED DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	4/24/69				
22d. PHYSICIAN'S NAME (Type)	JOHN B. UMHAU	22e. ADDRESS	8805 Conn. Ave. Chevy Chase Md		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	April 28, 1969	Arlington National	Arlington Virginia	
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	MAY 2 1969	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons	3210 M St. NW DC			

VR A15 (4) 45M - 1/69

1 05786

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Mrs. Middle: Charlotte S. Last: Wighaman
2a. DATE OF DEATH: Month April Day 18 Year 1969
2b. HOUR: 1105 AM
3. SEX: F
4. RACE: W
5. DATE OF BIRTH: Aug 1st 86
6. AGE (In years last birthday): 82 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. B RTHPLACE (State or foreign country): Penna.
7b. CITIZEN OF WHAT COUNTRY? American
8. MARRIED ☐ NEVER MARR ED ☐ WIDOWED ☒ D VORCED ☐
9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Takoma Park
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hospital
12a. USUAL OCCUPAT ON (Kind of work done during most of working l fe, even if retired): Practical Nurse
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admiss on) STATE: MD
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Takoma Park
13d. INSIDE C TY LIM TS? YES ☐ NO ☐
13e. STREET AND NUMBER: 780 Fairview Ave, Takoma Park
14. FATHER'S NAME First: Rankin Middle Last: McMonall
15. MOTHER'S MAIDEN NAME First: ? Middle Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war o dates of service):
16b. SOCIAL SECURITY NO: 172-16-3401A
17. INFORMANT: Robert R. Wighaman Address: Same as pt.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minute
450X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIA — minutes
DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EMBOLUS — days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFF CE BUILDING, ETC)
21f. LOCATION Street or R.F.D No City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 2-16, 19 69 to 2-18, 19 69, that (I) (we) last saw the deceased alive on 2-18 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: John L Ford DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 4-18-69
22d. PHYSICIAN'S NAME (Type): JOHN L. FORD, M.D.
22e. ADDRESS: 831 UNIVERSITY BLVD E SILVER SPRING MD. [redacted]

23a. BUR AL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-23-1969
23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
23d. LOCATION (City or Town) (County) (State): Ft. Matilda, Pa

24. FUNERAL DIRECTOR: Simmons Bros. ADDRESS: Wash DC
Simmons Bros 1661-Good Hope Rd SE
25a. RECD BY REGISTRAR DATE: APR 22 1969
25b. REGISTRAR'S SIGNATURE: Charles Smith

VR A15 (4) 45M 1/69

7 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLEARED BY DR. REAP HE WILL SIGN THIS CERTIFICATE AT THE FUNERAL HOME

05787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First: Byron	Middle: Hilton	Last: Wildermuth
2a DATE KNOWN OF DEATH ESTIMATED	Month 4 Day 4 Year 69		2b HOUR 8:55 AM
3 SEX: male	4 RACE: white	5. DATE OF BIRTH: 7/30/95	6 AGE (in years last birthday): 73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 4 Day 4 Year 19 69	2d HOUR 8:55 AM
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): Mechanical Engg.	12b KIND OF BUSINESS OR INDUSTRY: Engineering
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d INSIDE CITY LIMITS? YES X NO ☐
13e. STREET AND NUMBER: 304 Hamilton Avenue			
14. FATHER'S NAME: First Frederick Middle Albert Last Wildermuth		15. MOTHER'S MAIDEN NAME: First Mary Middle E. Last Snyder	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWI	16b SOCIAL SECURITY NO: 164 09 7179 M	17 INFORMANT: Mrs. Catherine Wildermuth	ADDRESS 304 Hamilton Ave Sil Sp Md.

MED CAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Artery Heart Disease.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO X
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.

ADDRESS (Street, City or county): Silver Spring

22b DATE SIGNED: April 5, 1969

23a. BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE: April 8, 1969	23c NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION (City or Town): Rockville	(County): (State): Maryland
24 FUNERAL DIRECTOR: Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Ave. Silver Spring, Md.	25a RECD BY REGISTRAR DATE: APR 10 1969	25b. REGISTRAR'S SIGNATURE: Mildred L. Sage	

VR A15ME (5) 10M REV 1/68

1

05788

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05783

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Baby	Middle: Boy	Last: Willard	2a. DATE OF DEATH: Month April Day 4, Year 1969	2b. HOUR: 3:37 PM	
3. SEX: MALE ~~Female~~	4. RACE: White	5. DATE OF BIRTH: 4-4-69	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN: 1	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery			Md
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wash. San & Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 636 Houston Ave., Apt 401		
14. FATHER'S NAME First: Robert	Middle: Edward	Last: Willard	15. MOTHER'S MAIDEN NAME First: Patricia	Middle: Ann	Last: Williamson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mother	Address:		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Fetal asphyxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Prolapsed cord

DUE TO, OR AS A CONSEQUENCE OF

(c): Premature; Breech presentation

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No.

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: O. B. Beardsley, M.D.	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 4-4-69	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 4-5-69	23c. NAME OF CEMETERY OR CREMATORY: Wash., San & Hospital	23d LOCATION (City or Town): Takoma Park, Mont., Md.	(County) (State)
24. FUNERAL DIRECTOR ADDRESS: J. D. Ruffcorn, Takoma Park, Maryland		25a. REC'D BY REGISTRAR DATE: APR 7 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Jones	

VR A15 [illegible]
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

05789 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05784

1. DECEASED NAME (Type or Print) First	Middle	Last
Bertie	V.	Williams

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 4 Day 3 Year 1969 — 2b. HOUR 1:25 A M

3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: July 18, 1896 — 6. AGE (In years last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD Month 4 Day 3 Year 1969 — 2d. HOUR 1:25 A M

7a. BIRTHPLACE (State or foreign country): Wash. D. C. — 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 9. COUNTY OF DEATH: Montgomery Md.

10. CITY OR TOWN OF DEATH: Takoma Park — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hosp — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Adm. National Geographic Society — 12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md. — 13b. COUNTY: Montgomery — 13c. CITY OR TOWN: Silver Spring — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 8712 Colesville Rd. #205

14. FATHER'S NAME First: Albert — Middle: M. — Last: Williams

15. MOTHER'S MAIDEN NAME First: Laura — Middle: V. — Last: Welsh S.S.Md

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)

16b. SOCIAL SECURITY NO: 579-48-8282

17. INFORMANT: Mrs. Estelle Nicholson — ADDRESS: 8712 Colesville Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 4

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Knapp M.D

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): BELDEN R. KNAPP, M.D.

ADDRESS (City, town, or county): Bethesda

22b. DATE SIGNED: April 3, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: April 5, 1969 — 23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery — 23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: P. J. Smith — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave. Silver Spring, Md.

25a. RECD BY REG STRAR DATE: APR 11 1969 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

1

Item? Film6412 MARYLAND STATE DEPARTMENT OF HEALTH Items 16&22a file 412

5/9/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 5-12-69 ams

05790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05785

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death

1. DECEASED NAME (Type or Print)	First: ~~JEROME~~ ~~Frances~~	Middle: OLIVER ~~Eugene~~	Last: WILLIAMS X ~~Kelly~~	2a DATE KNOWN OF DEATH / ESTIMATED	Month: 4-10	Day	Year: 69	2b HOUR: 2:30 PM
3 SEX: M	4. RACE: W	5. DATE OF BIRTH: 4-13-11	6 AGE (in years last birthday): 58 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c DATE PRONOUNCED DEAD: Month 4	Day 10	Year 69	2d HOUR: 2:30 PM

7a BIRTHPLACE (State or foreign country): Not known	7b CITIZEN OF WHAT COUNTRY?: Not known	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED (X)	9 COUNTY OF DEATH: Montgomery Md	
10 CITY OR TOWN OF DEATH: Takoma Pk	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Pk	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER: 64 Walnut Ave

14 FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS: mrs CECIL MURRAY SISTER PER DET. DA LPRYMPLE TK PK

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pneumonitis, rt. lung;

DUE TO, OR AS A CONSEQUENCE OF

(b) Fatty metamorphosis of liver, extensive

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 71.8

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES (X) / NO
21a EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy (X), Inspection (X), Inquiry (X), and in my opinion death resulted from. Natural causes (X), Accident ( ), Suicide ( ), Homicide ( ), Undetermined manner ( )

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Belden K. Leap M.D.

CHIEF MEDICAL EXAMINER ( )
ASSISTANT MEDICAL EXAMINER ( )
DEPUTY MEDICAL EXAMINER (X)
ADDRESS (Street, city, town, or county)

22b DATE SIGNED: APRIL 10, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE: 4.29.69	23c NAME OF CEMETERY OR CREMATORY: U. Md. Med. School	23d LOCATION (City or Town) (County) (State): Baltimore Md.	
24. FUNERAL DIRECTOR ADDRESS		25a RECD BY REGISTRAR DATE: MAY 1 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Juegen	

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05791 — 05786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14)
45M - 1 '69

1. DECEASED NAME (Type or print) First: William Middle: Valentine Last: Wilson		2a. DATE OF DEATH Month: April Day: 13 Year: 1969	2b. HOUR 9:47 P.M.
3. SEX: M.	4. RACE: Caucasian	5. DATE OF BIRTH: 10-20-90	6. AGE (In years last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): U.S.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 206 Upton St.
14. FATHER'S NAME First: Claiborne Middle: A. Last: Wilson		15. MOTHER'S MAIDEN NAME First: Maude Middle:	Last: Glascott
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes, give war or dates of service): 1917-1919	16b. SOCIAL SECURITY NO: 220-44-6349	17. INFORMANT: Maude Betts	Address: Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 103 X
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of prostate. — 9 months
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Sept 27, 1968, to April 13, 1969, that (I) (we) last saw the deceased alive on April 11 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen C. Cromwell, MD — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐			22c. DATE SIGNED: April 13, 1969
22d. PHYSICIAN'S NAME (Type): Stephen C. Cromwell, MD	22e. ADDRESS: 615 W. Montgomery Ave, Rockville, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-16-69	23c. NAME OF CEMETERY OR CREMATORY: Arlington, National	23d. LOCATION (City or Town) (County) (State): Arlington Virginia
24. FUNERAL DIRECTOR: Robert A Pumphrey	ADDRESS: 7557 Wisconsin Ave Bethesda, Md	25a. REC'D BY REGISTRAR DATE: APR 21 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05792

CERTIFICATE OF DEATH

05787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Lucia	Charlotte	Windle	April 22, 1969	11:40 A.M.

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	December 20, 1885	83 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH
Pennsylvenia	America		Montgomery Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Sanitarium	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Montgomery	Wheaton	YES ☒ NO ☐	2808 Hardy avenue

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John	Wesley	Adams	Ellen	A.	Lake

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	Address
no	183-01-1215-B	Mrs. Norton Spence ~~Patient's chart~~	Wheaton, Md. 2808 Hardy Ave.,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular Disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Carcinoma of Endometrium with metastasis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4-20, 1969, to 4-22, 1969, that (I) (we) last saw the deceased alive on 4-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Boris Rabkin MD					4-22-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
BORIS RABKIN, MD	1019 Chestnut Street

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Apr. 24, 1969	Forest Hills Cemetery	Philadelphia, Pennsylvania

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glen Carter Glen Carter Warner E. Pumphrey, Inc. Silver Spring, Md.	8434 Georgia Avenue	APR 25 1969	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05793 05788

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

1. DECEASED NAME (Type or print) First: ALICE	Middle: DOROTHEA	Last: WOOL	2a. DATE OF DEATH Month: 4 Day: 11 Year: 69 — 2b. HOUR: 4:45 PM
3. SEX: FEMALE	4. RACE: CAUC	5. DATE OF BIRTH: 15 MARCH 1918	6. AGE (In years last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): MASS.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: MONTGOMERY Md
10. CITY OR TOWN OF DEATH: BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): NAVAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): FSO-3 STATE DEPT.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: DISTRICE OF COLUMBIA	13b. COUNTY	13c. CITY OR TOWN: WASHINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 2301 "E" ST. N. W.
14. FATHER'S NAME First: UNK	Middle	Last: WOOL	15. MOTHER'S MAIDEN NAME First: ALICE	Middle: UNK	Last: SMULLEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 011 16 0531	17. INFORMANT: MARTHA CLAYPOOL	Address: 2039 ROCKINGHAM, MCLEAN, VA.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARCENOMA OF THE BREAST WITH WIDE SPREAD METASTASES
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) — 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 — 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 25 FEB. , 19 69 , to 11 APR. , 19 69 , that (I) (we) last saw the deceased alive on 11 APR. 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒ — 22c. DATE SIGNED: 12 APRIL 1969

22d. PHYSICIAN'S NAME (Type): LT. S. F. DOVI JR., MC, USN — 22e. ADDRESS: NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 14 APRIL 69	23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY	23d. LOCATION (City or Town) (County) (State): Washington, D. C.	
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc.,	ADDRESS: Washington, D. C.	25a. REC'D BY REGISTRAR DATE: APR 15 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 45M 1/69

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05794

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item6 Film6112 5/1/69 kk

CERTIFICATE OF DEATH

05789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please forward 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Viola Middle: [illegible] Last: Worthy

2a. DATE OF DEATH Month: 4 Day: 21 Year: 69

2b. HOUR: 10:30 PM

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH: 8/5/1884

6. AGE (In years last birthday) 84 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (State or foreign country): South Carolina

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md

10. CITY OR TOWN OF DEATH: Rockville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley Nsg. Home

12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): unemployed

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Washington,

13b. COUNTY: D.C.

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 4072 16th Street, N.W.

14. FATHER'S NAME First: David Middle: [illegible] Last: Kelly

15. MOTHER'S MAIDEN NAME First: Ellen Middle: [illegible] Last: Fant

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT Address: James Worthy-son-Box 34 Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Myeloma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic urinary tract infection

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If other, not by medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 3/27/69, 19__, to 4/22/69 19__, that (I) (we) last saw the deceased alive on 4/15/69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry C. Hemmeter DEGREE: ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED: 4/22/69

22d. PHYSICIAN'S NAME (Type)

22e. ADDRESS

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4/24/69

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cemetery

23d. LOCATION (City or Town) (County) (State): Maryland

24. FUNERAL DIRECTOR: John J. Stewart ADDRESS: 4001 Benning Rd NE

25a. RECD BY REGISTRAR DATE: APR 28 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A 15 (4-68) 45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05795

CERTIFICATE OF DEATH

05790

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Shirley	Anne	Yeatman	April 23, 1969	6:50 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	17 July 1934	34 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Delaware	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	The Clinical Center, NIH	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pennsylvania		West Grove	YES [ ] NO [X]	Box 99, R.D. #2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	D.	Boggs	Beatrice		Baldwin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT The Medical Record Address
no		The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Bronchopneumonia (bilateral)

DUE TO, OR AS A CONSEQUENCE OF (b) Hepatomegaly, Splenomegaly, massive-with focal infarcts

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myelogenous Leukemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours / Months-Years / 17 Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I (this hospital) attended the deceased from 20 February 19 69, to 23 April 19 69, that I (we) last saw the deceased alive on 23 April 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED
Paul P. Carbone MD					24 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Paul P. Carbone, M. D.	The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-27-69	London Grove Friends	Chester London Cty Pa

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md	MAY 5 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05796

CERTIFICATE OF DEATH

05791

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
BERTHA	O.	YOUNG	April 17, 1969	11:30 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	Cauc.	Aug. 23, 1882	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
New York	U. S.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	Bethesda-Silver Springs Nursing Home	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Chevy Chase	YES ☒ NO ☐	5435 Alta Vista Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Oliver	Abagail		Wilkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	577-12-6280B	Husband Ford E. Young, Sr.	Same as Item 13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	3-6 Mos
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertension	year
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	year

401 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19__, to April 17, 1969, that (I) (we) last saw the deceased alive on April 15 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George Sharpe MD		☒	☐	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
GEORGE SHARPE	Kensington, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-21-69	Rock Creek Cemetery	Washington, D. C.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland	APR 23 1969	[illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05797

CERTIFICATE OF DEATH

05792

1. DECEASED-NAME (Type or print) First: FREDERICK Middle: SION Last: YOUNG
2a. DATE OF DEATH Month: 4 Day: 2 Year: 69
2b. HOUR: 6 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: OCT 8, 1871
6. AGE (In years last birthday): 97 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Illinois
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: MONTGOMERY Md.
10. CITY OR TOWN OF DEATH: SILVER SPRING MD
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CHEVY CHASE NURSING HOME 2015 EAST WEST Highway
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ARMY OFFICER
12b. KIND OF BUSINESS OR INDUSTRY: ARMY OFFICER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: D.C
13b. COUNTY: —
13c. CITY OR TOWN: WASHINGTON
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: ARMY NAVY CLUB
14. FATHER'S NAME First: WILLIAM Middle: R. Last: YOUNG
15. MOTHER'S MAIDEN NAME First: MARY Middle: E Last: CAUDLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES (If yes give war or dates of service): 1898-1934
16b. SOCIAL SECURITY NO.: 529-16-3160
17. INFORMANT: MARY F. MATHESON Address: ARLINGTON, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO, OR AS A CONSEQUENCE OF
(b): Generalized arteriosclerosis — 10 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4369
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from Dec 4, 1968, to April 2, 1969, that (I) ~~(we)~~ last saw the deceased alive on April 1, 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Simon C. Weiner DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: April 2, 1969
22d. PHYSICIAN'S NAME (Type): SIMON C. WEINER
22e. ADDRESS: 8201-16th St. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 4/7/69
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
23d. LOCATION (City or Town) (County) (State): ARLINGTON VA.
24. FUNERAL DIRECTOR ADDRESS: JOSEPH GAWLER'S SONS, 5130 Wis. Ave. N.W. WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE: APR 7 1969
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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